



OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

CRASH REPORT

The owner or driver (or insurance company representative) of an insured vehicle that is involved in a crash with an uninsured vehicle may file this report with the Bureau of Motor Vehicles (BMV). In order to suspend the driving privileges of the uninsured party ALL of the following are required:

- This report must be received by the BMV within six months of the date of the crash. The crash must have occurred in Ohio.
- Property damage must exceed \$400, or there must be personal injury.
- A minimum of three identifiers that match BMV records (name, birth date, driver license number, SSN, etc.) are required for the party that is to be suspended.
- An itemized estimate or bill for property damage MUST be included.
- For personal injury, documentation of injuries must be provided for amounts over \$500.00. Proof that the insurance company has paid medical bills must be included.
- This report must be signed.

If this report does not meet all of the above criteria, a suspension will NOT be established. Incomplete reports will NOT be acknowledged or returned.

ACCIDENT INFORMATION (MUST HAVE OCCURRED IN OHIO)				
ACCIDENT DATE		TIME	# OF VEHICLES	
LOCATION (STREET)		LOCATION (CITY)	POLICE REPORT TAKEN? (PLEASE INCLUDE COPY) <input type="checkbox"/> Yes <input type="checkbox"/> No	
DRIVER TO BE SUSPENDED (MINIMUM OF 3 IDS REQUIRED THAT MATCH BMV RECORDS)				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE #	STATE	
DRIVER LICENSE #	STATE	SSN	DOB	
OWNER OF VEHICLE TO BE SUSPENDED (MINIMUM OF 3 IDS REQUIRED THAT MATCH BMV RECORDS)				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE #	STATE	
DRIVER LICENSE #	STATE	SSN	DOB	
DRIVER OF DAMAGED VEHICLE				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE #	STATE	
DRIVER LICENSE #	STATE	SSN	DOB	
OWNER OF DAMAGED VEHICLE				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE #	STATE	
DRIVER LICENSE #	STATE	SSN	DOB	

CLAIM INFORMATION			
IF YOU ARE AN INDIVIDUAL HANDLING YOUR OWN CLAIM PLEASE CHECK HERE <input type="checkbox"/>			
YOUR INFORMATION WILL BE GIVEN TO THE OTHER PARTY TO MAKE RESTITUTION			
INSURANCE COMPANY	POLICY #	CLAIM #	
OFFICE HANDLING CLAIM	PHONE	FILE #	
ADDRESS	CITY	STATE	ZIP
PROPERTY DAMAGE INFORMATION (MUST INCLUDE ESTIMATE AND EXCEED \$400)			
AMOUNT OF CLAIM			
PERSONAL INJURY INFORMATION (MUST INCLUDE DOCUMENTATION & FOR AMOUNTS OVER \$500, PROOF OF PAYMENT IS REQUIRED)			
NAME		PHONE	
ADDRESS		CITY	STATE ZIP
SSN	DOB	<input type="checkbox"/> DRIVER	<input type="checkbox"/> OWNER <input type="checkbox"/> PASSENGER
AMOUNT OF CLAIM			
SIGNATURE OF PERSON COMPLETING FORM (REQUIRED)			
X			DATE

Your signature and the filing of this report is a confirmation that the driver or owner of the damaged vehicle was insured at the time of the crash and the other party did not have insurance or another form of financial responsibility at the time of the crash.

INCOMPLETE REPORTS AND REPORTS RECEIVED AFTER 6 MONTHS FROM THE DATE OF THE ACCIDENT WILL NOT BE ACKNOWLEDGED OR RETURNED

MAIL COMPLETED REPORT TO:
 OHIO BUREAU OF MOTOR VEHICLES
 ATTN: COMPLIANCE UNIT
 P.O. BOX 16583
 COLUMBUS, OH 43216-6583

REPORTS WILL NOT BE PROCESSED LESS THAN 30 DAYS FROM THE DATE OF ACCIDENT
 PLEASE ALLOW 10 BUSINESS DAYS FOR PROCESSING