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, address, date of birth, Ohio Driver License Number, SSN) are required for the party that is to be suspended.
- An itemized estimate or bill for property damage MUST be included.
- For personal injury, form must be completed and documentation of injuries must be provided. Proof of payment is required for amounts over $500.
- This report must be signed.

ACCIDENT INFORMATION (MUST HAVE OCCURRED IN OHIO)		
ACCIDENT DATE	TIME	NUMBER OF VEHICLES
LOCATION (STREET)	LOCATION (CITY)	POLICE REPORT TAKEN? (PLEASE INCLUDE COPY) ☐ Yes ☐ 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 NUMBER	STATE	
OHIO DRIVER LICENSE NUMBER	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 NUMBER	STATE	
OHIO DRIVER LICENSE NUMBER	STATE	SSN	DOB	

DRIVER OF DAMAGED VEHICLE				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE NUMBER	STATE	
OHIO DRIVER LICENSE NUMBER	STATE	SSN	DOB	

OWNER OF DAMAGED VEHICLE				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE NUMBER	STATE	
OHIO DRIVER LICENSE NUMBER	STATE	SSN	DOB	

CLAIM INFORMATION

IF YOU ARE AN INDIVIDUAL HANDLING YOUR OWN CLAIM PLEASE CHECK HERE ☐ YOUR INFORMATION WILL BE GIVEN TO THE OTHER PARTY TO MAKE RESTITUTION. **NOTE**: **YOU SHOULD NOT COMPLETE THIS FORM IF YOUR INSURANCE COMPANY IS HANDLING THE CLAIM**.

INSURANCE COMPANY	POLICY NUMBER	CLAIM NUMBER	
OFFICE HANDLING CLAIM	PHONE	FILE NUMBER	
ADDRESS	CITY	STATE	ZIP

PROPERTY DAMAGE INFORMATION (MUST INCLUDE ESTIMATE AND EXCEED $400)

AMOUNT OF CLAIM

PERSONAL INJURY INFORMATION (MUST INCLUDE DOCUMENTATION. PROOF OF PAYMENT IS REQUIRED FOR AMOUNTS OVER $500)

NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
SSN	DOB	☐ DRIVER ☐ OWNER ☐ PASSENGER		

AMOUNT OF CLAIM

SIGNATURE OF PERSON COMPLETING FORM (REQUIRED)

	DATE
X	

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.

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