TENNESSEE DEPARTMENT OF SAFETY

OWNER / DRIVER REPORT

As set forth under the provisions of 55-12-104, T.C.A., you must file, or have filed in your behalf, a personal accident report with the Department of Safety, if you were involved in an automobile accident as an owner or driver involving death or injury, or in which damage to property was in excess of four hundred dollars ($400) to any person involved. This report is required regardless of who was at fault and in addition to any report filed by an investigating officer.

Failure to file a personal accident report with the Department of Safety shall result in the suspension of driver license and registrations or nonresident operating privileges of any person involved in an accident.

Your report must be submitted to this Department within **twenty (20) days** from the accident in order to avoid the proposed suspension of your driving and registration privileges. You can satisfy this requirement by completing the reverse side of this form and returning it to the Financial Responsibility Section, P.O. Box 945, Nashville, Tennessee 37202, (Telephone Number: 615/741-3954).

Thank you for your cooperation

Financial Responsibility Section

Investigating Officer _____

Agency _____

Telephone _____

SF-0395 (Rev. 11/89)

DO NOT WRITE BELOW THIS LINE

DEPARTMENTAL USE ONLY

TO THE INSURANCE COMPANY:

Please advise this Department whether or not your Company, as indicated on the reverse side, provide liability insurance coverage for this accident.

☐ YES ☐ NO

If no, reason for denial: _____

_____

_____

_____ _____

Signature of Authorized Representative

Name of Insurance Company

_____

Date

OWNER / DRIVER REPORT

IMPORTANT: COMPLETE FORM BELOW AND MAIL TO: FINANCIAL RESPONSIBILITY SECTION, P.O. BOX 945, NASHVILLE, TENNESSEE 37202.

Date of Accident _____
(Month) (Day) (Year) (Day of Week) (Time) (AM/PM)

Place of Accident _____
(City or Town) (County) (Street or Highway)

PROVIDE COMPLETE INFORMATION FOR YOU, THE OPERATOR AND/OR OWNER OF THE VEHICLE INVOLVED IN THIS ACCIDENT.

Vehicle Make_____ Vehicle Year_____ Type Vehicle_____ I.C.C. or Self-insured # _____

Name of Operator _____ DOB _____

Address_____ Zip _____

Driver License No.: _____ State _____ Expiration Date: _____

Name of Owner _____ DOB _____

Address_____ Zip _____

Driver License No.: _____ State _____ Expiration Date: _____

Were there injuries or death involved in this accident? ☐ Yes ☐ No

Damages to your vehicle: ☐ Less than $400 ☐ Over 400. If over $400 enter amount _____

If available, list following information on all other drivers involved in this accident:

_____
(Last Name) (First Name) (Middle Initial) (Driver License No.)

_____
(Last Name) (First Name) (Middle Initial) (Driver License No.)

_____
(Signature) (Date)

COMPLETE BUT DO NOT DETACH FORM BELOW

Date of Accident _____ Location of Accident _____ (County)

Did you have liability insurance coverage for this accident? Yes ☐ No ☐

If yes, provide complete information below:

Name of Insurance Company (Not Agency) _____

Address_____ Zip _____

Policy Number_____ Policy Period: From_____ to_____

Name of Operator _____ Address _____

Name of Policyholder _____ Address _____

Vehicle Make _____ Vehicle Year _____ Vehicle Type _____

Name of Insurance Representative (Agency) who issued policy_____

Address_____ Zip _____

NOTE: The insurance information you provide will be forwarded to the insurance company for verification.