



DEPARTMENT OF TRANSPORTATION
DRIVER AND MOTOR VEHICLE SERVICES
1905 LANA AVE NE, SALEM OREGON 97314

REPORT OF UNINSURED CRASH

This Form is for Insurance Companies ONLY

Send the completed form to:

Driver and Motor Vehicle Services
Crash Reporting Unit
1905 Lana Ave. NE
Salem OR 97314

INSTRUCTIONS: Use this form to notify DMV when a driver insured by your firm is involved in a crash with an **UNINSURED** driver. All of the form must be filled out or we cannot process it. **THIS FORM IS NOT INTENDED TO REPORT UNINSURED OWNERS.**

ORS 806.190 requires reporting the uninsured crash within 60 days of becoming aware of the crash.

LOCATION AND DATE

CRASH DATE	DAY OF WEEK	TIME OF DAY <input type="checkbox"/> AM <input type="checkbox"/> PM	DO NOT WRITE IN THIS SPACE
COUNTY	CITY NAME [OR NEAREST CITY]		CRASH NUMBER
If outside city limits, indicate distance from nearest city: _____ MILES		<input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W	CRASH TYPE CODE [CIRCLE ONE]
OCCURRED ON [NAME OF STREET, ROAD OR ROUTE]		OCCURRED ON [NAME OF STREET, ROAD OR ROUTE]	1 2 3 4 5 6 7 8 X R P

UNINSURED DRIVER INFORMATION

UNINSURED DRIVER'S NAME [LAST FIRST MIDDLE]			
UNINSURED DRIVER'S ADDRESS			
CITY, STATE, ZIP CODE			
DRIVER LICENSE NUMBER		STATE OF ISSUE	DATE OF BIRTH
VEHICLE PLATE NUMBER	STATE	YEAR OF VEHICLE	MAKE STYLE
AMOUNT OF DAMAGE \$		DID THE CRASH CAUSE INJURY? -- ANY INJURY, NO MATTER HOW MINOR, MUST BE REPORTED. <input type="checkbox"/> YES <input type="checkbox"/> NO	
EXPLAIN HERE WHY YOU BELIEVE VEHICLE IS UNINSURED:			

INSURED DRIVER INFORMATION

INSURED DRIVER'S NAME [LAST FIRST MIDDLE]			
INSURED DRIVER'S ADDRESS			
CITY, STATE, ZIP CODE			
DRIVER LICENSE NUMBER		STATE OF ISSUE	DATE OF BIRTH
VEHICLE PLATE NUMBER	STATE	YEAR OF VEHICLE	MAKE STYLE
AMOUNT OF DAMAGE \$		DID THE CRASH CAUSE INJURY? -- ANY INJURY, NO MATTER HOW MINOR, MUST BE REPORTED. <input type="checkbox"/> YES <input type="checkbox"/> NO	

INSURANCE CARRIER INFORMATION

INSURANCE COMPANY NAME	PRINTED NAME OF COMPANY REPRESENTATIVE	PHONE NUMBER
ADDRESS [CITY, STATE AND ZIP CODE]		
SIGNATURE X	TITLE	CLAIM NUMBER
INSURED'S POLICY NUMBER		