Reset Form

Alabama Department of
Public Safety

(PLEASE PRINT OR TYPE)

Driver License Division
Safety Responsibility Unit
P. 0. Box 1471
Montgomery, AL 36102-1471

For Office Use Only
DOC No.
Case No.

COMPLETION OF THIS FORM IS REQUIRED BY §32-7-1, CODE OF ALABAMA 1975. FAILURE TO FILE A REPORTABLE ACCIDENT ON THIS FORM MAY RESULT IN SUSPENSION OF YOUR DRIVER LICENSE.

INFORMATION AND INSTRUCTIONS: Completion of this form is required ONLY if a motor vehicle accident occurring in Alabama caused death, personal injury, or property damage to any one owner in excess of $250. The driver is legally required to file a report on this form with the Department of Public Safety within thirty (30) days after the accident regardless of who is at fault and regardless of whether or not the vehicle involved was covered by liability insurance at the time of the accident. If a driver is physically incapable of making such report, the owner of the motor vehicle involved in such accident, within thirty (30) days after learning of the accident, make such report. Use additional forms if necessary.

YOU MUST FILL IN ALL INFORMATION FOR PROCESSING

DATE OF ACCIDENT	TIME: A. M. P. M.	HOW MANY VEHICLES WERE INVOLVED	For Office Use Only
LOCATION OF ACCIDENT (CITY) (STREET/HWY)		COUNTY	

YOUR INFORMATION (PLEASE PRINT OR TYPE)	OTHER PARTY'S INFORMATION (PLEASE PRINT OR TYPE)
YOU ARE THE: ☐ DRIVER ☐ PEDESTRIAN ☐ PROPERTY OWNER ☐ OTHER ☐ PARKED ☐ HIT & RUN	OTHER PARTY WAS ☐ DRIVER ☐ PEDESTRIAN ☐ PROPERTY OWNER ☐ OTHER ☐ PARKED ☐ HIT & RUN
DRIVER'S NAME (FIRST, MIDDLE, LAST) TELEPHONE NO.	DRIVER'S NAME (FIRST, MIDDLE, LAST) TELEPHONE NO.
CURRENT ADDRESS: STREET NO.	CURRENT ADDRESS: STREET NO.
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
DRIVERS DATE OF BIRTH / SEX ☐ M ☐ F / DRIVER LICENSE # / STATE	DRIVER'S DATE OF BIRTH / SEX ☐ M ☐ F / DRIVER LICENSE NUMBER / STATE
OWNER OF VEHICLE/PROPERTY / IF SAME AS DRIVER, MARK BOX ☐	OWNER OF VEHICLE/PROPERTY / IF SAME AS DRIVER, MARK BOX ☐
ADDRESS OF OWNER: STREET NO.	ADDRESS OF OWNER: STREET NO.
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE

YOUR VEHICLE					OTHER VEHICLE (Use additional form if more than two (2) vehicles)				
YEAR	MAKE	TYPE	COMMERCIAL VEHICLE ☐ YES ☐ NO	STATE	YEAR	MAKE	TYPE	COMMERCIAL VEHICLE ☐ YES ☐ NO	STATE
VIN	LICENSE PLATE NO.				VIN	LICENSE PLATE NO.			

PROPERTY DAMAGE

DESCRIPTION OF PROPERTY DAMAGE (OTHER THAN VEHICLE, HOUSE/FENCE, UTILITY POLE/ETC)

INSURANCE INFORMATION ON BACK MUST BE COMPLETED AND SIGNED

(COMPLETE REVERSE SIDE)

SR-13
(Revised 1-98)

YOUR INSURANCE INFORMATION

Complete the following as required by the Safety Responsibility Law of Alabama §32-7-1, and following sections. Mark only the appropriate box. All information will be verified.

☐ 1. When accident occurred, the vehicle I was driving was covered by liability insurance with

_____

(List name of insurance company, not Agency's name)

POLICY NO. _____

POLICY PERIOD FROM _____ TO _____

POLICY HOLDER _____

☐ 2. When accident occurred, the vehicle I was driving was not covered by liability insurance

☐ 3. Form SR-23 (Fleet Policy) is on file with Department of Public Safety.

☐ 4. Your vehicle is a qualified carrier with Alabama Public Service Commission.

☐ 5. Department of Public Safety Self-Insurance Certificate No.

_____

SIGNATURE _____ DATE _____

INJURED PERSONS IN YOUR VEHICLE ☐ NONE

FULL NAME OF INJURED IN YOUR VEHICLE		DID INJURED DIE? ☐ YES ☐ NO
ADDRESS: STREET NO.		
CITY	STATE	ZIP
DATE OF BIRTH	SEX ☐ M ☐ F	INJURED WAS (Please Circle) DRIVER PASSENGER PEDESTRIAN OTHER

FULL NAME OF INJURED IN YOUR VEHICLE		DID INJURED DIE? ☐ YES ☐ NO
ADDRESS: STREET NO.		
CITY	STATE	ZIP
DATE OF BIRTH	SEX ☐ M ☐ F	INJURED WAS (Please Circle) DRIVER PASSENGER PEDESTRIAN OTHER

INFORMATION AND INSTRUCTIONS: Complete this portion of the form if you believe that another party is responsible for your damages and you have not been compensated for them. You must give vehicle and/or other damages in dollar amount.

VEHICLE AND/OR OTHER PROPERTY DAMAGE

I, _____ (Full Name of Person Making Claim) certify that damages to my property amounted to $ _____ (Amount of Damage) as a result of this motor vehicle accident. I believe I am entitled to recover the amount specified from _____ (Driver of Vehicle) and from _____ (Owner of Vehicle), and I have not released said party(ies).

Signature of Property Owner _____ (If owner is a company, give title of person signing claim.)

INJURIES (Please complete one section for each party injured)

I, _____ (Full Name of Person Injured) certify that my medical expenses are $ _____ (Amount of Injury) as a result of this motor vehicle accident. I believe I am entitled to recover the amount specified above from _____ (Driver of Vehicle) and from _____ (Owner of Vehicle), and I have not released said party(ies).

Signature of Claimant/Legal Guardian of Minor _____ Date _____

I, _____ (Full Name of Person Injured) certify that my medical expenses are $ _____ (Amount of Injury) as a result of this motor vehicle accident. I believe I am entitled to recover the amount specified above from _____ (Driver of Vehicle) and from _____ (Owner of Vehicle), and I have not released said party(ies).

Signature of Claimant/Legal Guardian of Minor _____ Date _____

FORM COMPLETION REVIEW

1. Review form to ensure all blanks have been filled in.
2. Use your full, legal name.
3. Describe all property damage (Example: bicycle, farm equipment, house, fence, etc.)
4. Sign and date this form in spaces provided.
5. Use additional forms, if necessary. Be sure to include all information requested.
6. For more information call 334-242-4222.