

DR 2301 (09/01)  <b>Confidential Report</b>  NOT OPEN TO PUBLIC INSPECTION AND CAN ONLY BE USED IN ACCORDANCE WITH 42-4-1610, 42-7-504, C.R.S. <b>FILL OUT COMPLETELY TO AVOID A SECOND REPORT.</b>	<h2 style="margin:0;">STATE OF COLORADO REPORT OF MOTOR VEHICLE ACCIDENT</h2> <p style="margin:0; color: red;">This report must be filed if insurance information was not reported to a law enforcement agency. <b>Failure to report may cause suspension of your driving privilege. A certified written statement may be required to substantiate damage to your vehicle or property. A doctors statement may be required to substantiate any injuries.</b></p> <p style="margin:0; background-color: #e0e0e0; padding: 2px;">You may receive a letter requiring you to file this report if any other party involved files.</p> <p style="margin:0; text-align: center;"><b>WITHIN 10 DAYS FOLLOWING THE ACCIDENT MAIL TO:</b>            Colorado Department of Revenue/Motor Vehicle Business Group            Driver Services, Denver, CO 80261-0016  <b>OR BRING TO:</b>            1881 Pierce, Lakewood, CO            (303) 205-5613</p>	<b>FINANCIAL RESPONSIBILITY SECTION USE ONLY</b>
---	--	--

<b>DATE AND LOCATION OF ACCIDENT</b>	Date of Accident	MO	DAY	YR	City where accident occurred	County where accident occurred
	Street or Highway where accident occurred	Intersecting Street or Highway			Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Day of Week

<b>YOUR INFORMATION HERE</b>  <b>1</b>	<input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian <input type="checkbox"/> Property Owner <input type="checkbox"/> Vehicle Owner <input type="checkbox"/> Bicycle <input type="checkbox"/> Parked Motor Vehicle <input type="checkbox"/> Other												
	Driver's Name (first, middle, last)					Street Address							
	City			State		ZIP		Date of Birth		Sex	Driver's License No.	State	<input type="checkbox"/> Killed <input type="checkbox"/> Injured
	License plate #		Year	State	Approximate dollar amount of damage \$			Make of Vehicle		Model	Year		
	Describe Damage to Vehicle or Property												
	Owner's Name (first, middle, last) <input type="checkbox"/> Same as driver						Address (street, city, ZIP)						

Was an automobile liability policy for this vehicle in effect on the accident date?    yes    no

Is form SR 23 (Fleet Coverage) on file with this department?    yes    no

If self-insured give the certificate number. \_\_\_\_\_

**Use the liability policy that was in effect at the time of the accident to complete the insurance information.**

<b>I N S U R A N C E</b>	Name of Policyholder <input type="checkbox"/> Same as driver														
	Name of insurance company that issued your policy to cover liability for damage or injury to others.														
	Home Office Address														
	Agency that sold policy						Address								
	Policy Number				Period of Policy in effect at time of accident		From		MO	DAY	YR	To	MO	DAY	YR
	Make of your Vehicle (# 1)				Model		Year		Identification or Serial Number						

IF MORE THAN ONE VEHICLE WAS INVOLVED, DESCRIBE THE OTHER VEHICLES ON THE REVERSE SIDE OF THIS FORM. USE ADDITIONAL FORMS IF NECESSARY.

<b>OTHER PROPERTY INFORMATION</b>	Approximate cost to repair damage to property other than vehicles. \$	Description of damaged property	Name and address of property owner
-----------------------------------	---	---------------------------------	------------------------------------

I CERTIFY THAT STATEMENTS ON BOTH SIDES OF THIS REPORT ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Sign Here \_\_\_\_\_
 Signature of person making report is required
Address
Date of report

<b>OTHER PERSON'S INFORMATION</b>	<input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian <input type="checkbox"/> Property Owner <input type="checkbox"/> Vehicle Owner <input type="checkbox"/> Bicycle <input type="checkbox"/> Parked Motor Vehicle <input type="checkbox"/> Other												
	Driver's Name (first, middle, last)						Street Address						
	City			State	ZIP		Date of Birth MO DAY YR		Sex	Driver's License Number		State	<input type="checkbox"/> Killed <input type="checkbox"/> Injured
	License Plate #	Year	State	Approximate dollar amount of damage \$				Make of Vehicle		Model		Year	
	Describe Damage to Vehicle or Property												
<b>2</b>	Owner's Name (first, middle, last) <input type="checkbox"/> Same as driver						Address (street, city, ZIP)						

<b>OTHER PERSON'S INFORMATION</b>	<input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian <input type="checkbox"/> Property Owner <input type="checkbox"/> Vehicle Owner <input type="checkbox"/> Bicycle <input type="checkbox"/> Parked Motor Vehicle <input type="checkbox"/> Other												
	Driver's Name (first, middle, last)						Street Address						
	City			State	ZIP		Date of Birth MO DAY YR		Sex	Driver's License Number		State	<input type="checkbox"/> Killed <input type="checkbox"/> Injured
	License Plate #	Year	State	Approximate dollar amount of damage \$				Make of Vehicle		Model		Year	
	Describe Damage to Vehicle or Property												
<b>3</b>	Owner's Name (first, middle, last) <input type="checkbox"/> Same as driver						Address (street, city, zip)						

<b>OTHER PERSON'S INFORMATION</b>	<input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian <input type="checkbox"/> Property Owner <input type="checkbox"/> Vehicle Owner <input type="checkbox"/> Bicycle <input type="checkbox"/> Parked Motor Vehicle <input type="checkbox"/> Other												
	Driver's Name (first, middle, last)						Street Address						
	City			State	ZIP		Date of Birth MO DAY YR		Sex	Driver's License Number		State	<input type="checkbox"/> Killed <input type="checkbox"/> Injured
	License Plate #	Year	State	Approximate dollar amount of damage \$				Make of Vehicle		Model		Year	
	Describe Damage to Vehicle or Property												
<b>4</b>	Owner's Name (first, middle, last) <input type="checkbox"/> Same as driver						Address (street, city, zip)						

<b>F I N I S H E D I N G I N F O R M A T I O N</b>	<input type="checkbox"/> Passenger	Vehicle #	Name (First, middle, last)								
	<input type="checkbox"/> Pedestrian										
	Street Address			City			State	ZIP		Age	<input type="checkbox"/> Killed <input type="checkbox"/> Injured
	<input type="checkbox"/> Passenger	Vehicle #	Name (First, middle, last)								
	<input type="checkbox"/> Pedestrian										
	Street Address			City			State	ZIP		Age	<input type="checkbox"/> Killed <input type="checkbox"/> Injured
	<input type="checkbox"/> Passenger	Vehicle #	Name (First, middle, last)								
	<input type="checkbox"/> Pedestrian										
Street Address			City			State	ZIP		Age	<input type="checkbox"/> Killed <input type="checkbox"/> Injured	

Did a law enforcement officer investigate at scene of accident? (Highway Patrol, Sheriff, City Police, etc.)  yes  no

Name of Investigating Officer \_\_\_\_\_ Department \_\_\_\_\_

Was a traffic citation issued  yes  no

Issued to \_\_\_\_\_ Violation \_\_\_\_\_

Issued to \_\_\_\_\_ Violation \_\_\_\_\_

**Describe what happened** (refer to other persons by number, explain what caused the accident). \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_