

For office use only

Sheet _____ of _____ sheet(s)



South Carolina Department of Motor Vehicles

TRAFFIC COLLISION REPORT Not Investigated by Law Enforcement

FR-309
(Est. 7/05)

According to South Carolina Law 56-5-1270, the driver or owner of a vehicle which is in any manner involved in an accident that is not investigated by law enforcement that results in total property damages of one thousand dollars or more or in death or bodily injury, shall complete and send this form to South Carolina Department of Motor Vehicles, Financial Responsibility, P.O. Box 1498, Blythewood, SC 29016-0040 within 15 days of the collision.

Date of collision	Day of Week	Time	am pm	County collision occurred	<u>ON</u> what street did it occur:
<u>AT</u> what intersection did it occur, if applicable (street name):				<u>IN</u> what city or town did it occur:	

Your Vehicle	Driver's Full Name			Street			City		State	Zip Code		<p>Circle Point of Areas Damaged</p>
	Date of Birth	Sex	Race	Driver's License Number		State	Home Phone		Work Phone			
	Make	VIN		Body	Year	Tag number	State	Legally Parked ? (circle one) Yes / No				
	Owner's Name			Street			City		State	Zip Code		
	Type of Vehicle (circle one): 01- Auto 03- Sta. Wagon 05- TR. Tractor 07- Farm 09- School Bus 11- Motorcycle 02- Bicycle 04- Panel-Pickup 06- Other Truck 08- Comm. Bus 10- Other Bus 12- Other: (Description) _____											

Other Vehicle or Pedestrian	Other Driver's or Pedestrian's Full Name			Street			City		State	Zip Code		<p>Circle Point of Areas Damaged</p>
	Date of Birth	Sex	Race	Driver's License Number		State	Home Phone		Work Phone			
	Make	VIN		Body	Year	Tag number	State	Legally Parked ? (circle one) Yes / No				
	Owner's Name			Street			City		State	Zip Code		
	Type of Vehicle (circle one): 01- Auto 03- Sta. Wagon 05- TR. Tractor 07- Farm 09- School Bus 11- Motorcycle 02- Bicycle 04- Panel-Pickup 06- Other Truck 08- Comm. Bus 10- Other Bus 12- Other: (Description) _____											

Damage to property other than vehicle (for example: fence, guardrail, mailbox, building, etc.)						
Name of owner		Street		City	State	Zip Code

FR-309a

COMPLETE REVERSE SIDE ALSO

- Check here if a Form SR-23, Fleet policy of 25 or more vehicles is on file with the Department covering your vehicle.
- Check here if a certificate of self-insurance has been issued by the department covering your vehicle and indicate the certificate number _____
- Check here if liability insurance was not in effect for your vehicle to comply with South Carolina Statutory Requirements.
(If any of the above are applicable, disregard the below portion)

TO THE VEHICLE OWNER:

You are hereby required to return this form to the Department of Motor Vehicles, Financial Responsibility, P.O. Box 1498 Blythewood, SC 29016-0040 with the below portion completed by an authorized agent or representative of your insurance company showing that on the date and time stated above when the motor vehicle was being operated, that it was an insured motor vehicle. If the Department does not receive this form within 15 days from the date of the accident, the owner's registration and/or driving privileges in this state could be suspended.

TO BE COMPLETED BY INSURANCE AGENCY, BROKER, OR OTHER INSURANCE COMPANY REPRESENTATIVE

I hereby affirm that to the best of my knowledge the policy described below was in effect covering the vehicle listed on the date and time as mentioned. (Failure to complete all information below will result in refusal of this form)

Name of Insurance Company

Policy Number

FROM: _____ TO: _____

Policy Holder

The information as contained herein is based solely upon my knowledge and belief as a representative of the above insurance company and no warranty of liability is imputed to the above mentioned insurance company as I have listed herein.

Signature of Authorized Representative

Title

Phone Number

NAIC Code Number

*(If insurance agent or broker indicate corresponding company code number assigned by the South Carolina Department of Insurance, indicate whether agent, broker, etc.)

Return this form to: S.C. Department of Motor Vehicles, Form FR-309, Financial Responsibility, Box 1498, Blythewood, SC 29016-0040

FOR INSURANCE COMPANY REPRESENTATIVE USE ONLY

FOR INSURANCE COMPANY REPRESENTATIVE USE ONLY

CODES	USE APPROPRIATE CODES IN BLOCKS PROVIDED	<table border="1" style="margin: auto;"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>4</td><td>5</td><td>6</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table>	1	2	3	4	5	6	7	8	9	SEATING M-Motorcycle B- Bicycle O - Other U - Unknown P - Pedestrian	RESTRAINT/SAFETY DEVICE 00 - Not Used 11 - Shoulder Belt Only 12 - Lap Belt Only 13 - Shoulder & Lap Belt 21 - Child Safety Seat 88 - Other	INJURY 0 - No Injury 1 - Possible Injury 2 - Injury/non-life threatening 3 - Injury/life threatening 4 - Death
		1	2	3										
		4	5	6										
7	8	9												

VICTIMS		AGE	SEX	VEHICLE NUMBER	SEATING	SAFETY BELTS	INJURY
	Name						
	Taken To:		Taken By:				
Name							
Taken To:		Taken By:					
Name							
Taken To:		Taken By:					
Name							
Taken To:		Taken By:					
Name							
Taken To:		Taken By:					

WITNESSES	Name	Home Number	Work Number	Cell Number
	Name	Home Number	Work Number	Cell Number
	Name	Home Number	Work Number	Cell Number

NARRATIVE	Please describe how the collision happened. Include factors that may have contributed to the collision such as road conditions, weather conditions, terrain, etc.

THE PERSON MAKING THIS REPORT MUST SIGN HERE

X		
Signature	Address	Date