AFFIDAVIT

I, ____, make oath in
Name

due form of law that I suffered property damage in the amount of $____________________ and personal injury in the amount of $_________________ ** as a result of a motor vehicle accident which occurred on the ____________________ day of ____________________,20____, in the City of ___________________________ and/or in the County of _______________________.

I believe myself entitled to recovery of the above amount from the driver, ___________________
Name
______________, driver's license number ______________ date of birth _________________

and/or the owner ____
Name
driver's license number __________________ date of birth _________________________ of the other motor vehicle(s) involved in such accident. I have not released the parties from this claim nor has any judgment been rendered against me in any court as a result of this accident.

This ____________________________ day of ______________________, 20____.

____
SIGNATURE OF LEGAL OWNER OF DAMAGED PROPERTY
AND/OR INJURED PARTY

MUST BE NOTARIZED

Sworn to and subscribed before me this ______________ day of ________________, 20____.

____
NOTARY PUBLIC SIGNATURE (AFFIX SEAL)

My commission expires __________________________________

** ON PERSONAL INJURY CLAIMS, REVERSE SIDE MUST BE EXECUTED (COMPLETED) IN DETAIL BY CLAIMANT AND ATTENDING PHYSICIAN, OR CLAIM WILL NOT BE PROCESSED.

COMPLETE AND RETURN TO:
Department of Driver Services
Safety Responsibility Unit
P.O. BOX 80447
CONYERS, GEORGIA 30013

PERSONAL INJURY SUPPLEMENT

SECTION I – TO BE COMPLETED BY THE INJURED PERSON

AFFIDAVIT

I, ____ make oath in due form of
Name
Law that the following information is true:

I was (check one): Driver ( ) Passenger ( ) Pedestrian ( )

Other ____________________

My occupation ______________________________ Weekly Salary ________________________

Actual work days lost by me due to injury ____

Name and address of my employer ____

____

In witness set my hand this _______________ day of ______________________, 20_________

Signature ____

Sworn to and subscribed before me this ______________ day of ___________________, 20___

____
NOTARY PUBLIC SIGNATURE (AFFIX SEAL)
My commission expires _____________________________________

SECTION II – TO BE COMPLETED BY THE PHYSICIAN

Description and nature of injuries to:____

____
(NAME AND ADDRESS OF PATIENT)

Patient hospitalized: Yes ( ) No ( ) If yes, how many days _____________

Total medical cost of recovery from injury $____

Signature of attending physician ____

Address ____

Phone Number _____________________________ Date ________________________________