

JOB INJURY INFORMATION (circle all that apply)

Date of Injury ___/___/___ Time ___ am/pm Location _____

Description of accident _____

Did you report the injury? YES or NO Workers Compensation Claim # _____

Insurance Company Name _____ Phone # (____) _____ - _____

Address _____

Are you working now? YES or NO If NO, Date(s) unable to work _____

Did you go to the hospital? YES or NO List the X-rays taken _____

AUTO ACCIDENT INFORMATION (circle all that apply)

Date of Accident ___/___/___ Time ___ am/pm Vehicle Type MID SIZE FULL SIZE

Were you the DRIVER FRONT PASSENGER REAR PASSENGER PEDESTRIAN

Approximate speed of your vehicle at the time of impact ___ MPH

Were you wearing a seatbelt? YES or NO Were you wearing a shoulder harness? YES or NO

What position were your head restraints in? HIGHEST MIDDLE LOWEST

Did your airbags deploy? YES NO NOT INSTALLED/ACTIVATED

Did you see the accident coming? YES or NO

Were you: FACING FORWARD LOOKING RIGHT LOOKING LEFT

Upon impact, were you thrown: VIOLENTLY GENTLY

Which way was your body thrown? RIGHT LEFT FORWARD BACKWARD

Your mental/emotional state after impact was: CONSCIOUS UNCONSCIOUS CONFUSED

Were you hit: FROM BEHIND A VEHICLE HIT YOU YOUR VEHICLE HIT ANOTHER
RIGHT FRONT RIGHT REAR RIGHT MIDDLE
LEFT FRONT LEFT REAR LEFT MIDDLE

Description of accident _____

Approximate speed of other vehicle at the time of impact ___ MPH

Impact point of other vehicle: RIGHT FRONT RIGHT REAR RIGHT MIDDLE
FRONT BEHIND LEFT FRONT LEFT REAR LEFT MIDDLE

Did any part of your body during the accident, come in contact with:

DASHBOARD STEERING WHEEL DOOR REAR VIEW MIRROR
WINDSHEILD SEAT FRAME ANOTHER PERSON UNKNOWN OBJECT

Which body part? _____

After the accident you DROVE HOME WERE DRIVEN HOME TAKEN TO HOSPITAL

Name of Hospital _____ List the X-rays taken _____

Are you working now? YES or NO If NO, Date(s) unable to work _____

YOUR VEHICLE INFORMATION

Insurance Company Name _____ Phone # (____) _____ - _____

Address _____

Policy # _____

Have you been contacted by an Insurance Adjuster or Company about this claim? YES or NO

Attorney Name _____ Phone# (____) _____ - _____

Address _____

OTHER VEHICLE INFORMATION

Insurance Company Name _____ Phone # (____) _____ - _____

Address _____

Policy # _____

Drivers Name _____ Date of Birth ___/___/___

Is the driver the registered owner of the vehicle? YES or NO
NO. Drivers Insurance Company and phone # _____