NAME_____**DATE**_____

VEHICLE ACCIDENT INFORMATION:

Date of Accident: Time of Accident: am □ pm □

Road/Street Name:

City, State: Direction You Were Headed:

Nearest Intersection with Road/Street:

Driving Conditions: Dry □ Wet □ Icy □ Other □ Speed You Were Traveling:

Were you the : Driver □ Front Passenger □ Rear Passenger □ Pedestrian □ How many people were in the accident vehicle:

Make and Model of the Vehicle You Were In:

Were You Wearing a Seatbelt: □ Yes □ No If Yes, What Type: □ Shoulder Harness □ Lap Belt

Was Vehicle Equipped with Airbag? □ Yes □ No If Yes, did it/they inflate properly: □ Yes □ No

Did Your Seat Have a Headrest: □ Yes □ No If Yes, What was the Position of the Headrest: □ Low □ High □ Mid

Did Any Part of Your Body Strike the Inside of the Vehicle: □ Yes □ No Describe:

Did Your Car Impact Another Vehicle: □ Yes □ No Another Structure: □ Yes □ No

Make and Model of Other Vehicle: Speed of Other Vehicle:

Direction of Other Vehicle:

Was Impact from: □ Rear □ Front □ Left □ Right □ Other

At the Time of Impact Were You: Looking Straight Ahead □ Looking to the Left □ Looking to the Right □ Looking Up □ Down □

Were Both Hands on the Steering Wheel: □ Yes □ No If Not, Which Hand was on the Wheel:

Was Your Foot on the Brake: □ Yes □ No

Were You: □ Surprised by the Impact □ Braced for the Impact

Did the Police Come to the Accident Site: □ Yes □ No Was a Report Filed: □ Yes □ No

Were there any Witnesses: □ Yes □ No Was a Traffic Violation Issued: □ Yes □ No To Whom:

Describe the Accident in Your Own Words:

Were you Unconscious after the Accident: □ Yes □ No

Did You go to the Hospital: □ Yes □ No By Ambulance: □ Yes □ No Next Day: □ Yes □ No Other:

Name of Hospital: Name of Doctor:

Diagnosis:

Treatment Received:

X-Rays Taken:

Have you been able to work since the accident: □ Yes □ No If not, how many days have you missed: