

# ACCIDENTAL INJURY FORM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time: \_\_\_ am \_\_\_ pm Location of Accident \_\_\_\_\_

Dollar amount of damage sustained by your vehicle? \_\_\_\_\_

Make and model of your vehicle? \_\_\_\_\_

Make and model of responsible party's vehicle? \_\_\_\_\_

Was your car damage: ( ) minimal ( ) moderate ( ) severe

## AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

## ON-THE-JOB INJURY

How did the injury occur? \_\_\_\_\_

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

## OTHER

Describe the circumstances of the accident (Be Specific) \_\_\_\_\_

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## CHECK SYMPTOMS YOU HAVE NOTIED SINCE THE ACCIDENT

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Diarrhea      | <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Neck Stiff   |
| <input type="checkbox"/> Feet Cold     | <input type="checkbox"/> Head Too Heavy         | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Nervousness  |
| <input type="checkbox"/> Hands Cold    | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ears Ringing       | <input type="checkbox"/> Dizziness    |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Face Flushed       | <input type="checkbox"/> Back Pain    |
| <input type="checkbox"/> Constipation  | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Buzzing in Ears    | <input type="checkbox"/> Tension      |
| <input type="checkbox"/> Cold Sweats   | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Loss of Balance    | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Fever         | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Chest Pain   |
| <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Loss of Smell          | <input type="checkbox"/> Loss of Taste      | <input type="checkbox"/> Neck Pain    |
| <input type="checkbox"/> Headache      | <input type="checkbox"/> Depression             |   |                                       |
| <input type="checkbox"/> Other         |   |   |                                       |

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, \_\_\_\_\_ through \_\_\_\_\_

## INSURANCE INFORMATION

Your Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Other Party's Name \_\_\_\_\_ Address \_\_\_\_\_

Other Party's Ins. Co. \_\_\_\_\_ Address \_\_\_\_\_

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjuster \_\_\_\_\_ Company \_\_\_\_\_

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_