ACCIDENTAL INJURY FORM

NAME_____ DATE_____

Date of Accident_____ Time: ___am ___pm Location of Accident_____

AUTO INJURY

Were You: ( ) Driver ( ) Front Passenger ( ) Rear Passenger L M R ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Driver's Side ( ) Passenger's 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 NOTICED SINCE THE ACCIDENT

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

Did you require post-accident hospitalization? ( ) No ( ) Yes, Where: _____
If yes, where you transported by ambulance? ( ) 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 adjustor_____Company_____

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

If yes, attorney's name_____Address_____

Signature_____