Name: _____ Date: _____

ACCIDENT INFORMATION:

Date of Injury: _____ Time: _____ Location: _____

Description of accident: _____

_____

_____

What injuries did you have: _____

Were you unconscious: _____ Fractures _____

Cuts _____ Bruises _____

Patient taken to: _____ Treatment: _____

Confined to hospital for: _____ days _____ hours. Hospital doctor: _____

WORK INJURY:

Reported to employer: _____ Supervisor's Name: _____

Phone Number: _____

AUTOMOBILE ACCIDENT:

Driver / Passenger / Pedestrian

Seat Belt: _____

Was your car struck from ❑ behind ❑ right side ❑ left side ❑ front

Year & Model of car you were in: _____

Year & Model of other vehicles involved: _____

Amount of damage to car you were in: _____

Auto Insurance for car you were in:

Policy Holder: _____

Insurance Company Name: _____

Adjuster's Name: _____ Phone: _____

Claim #: _____

Do you have an attorney: _____

Attorney Name: _____

Address: _____

Phone: _____