Accident Report Form

Name:____ Today's Date:___________________
Date and Time of Injury:____
Accident Location:____
How Accident Occurred:____
____
What Part of Your Body Was Injured:____
____
What effects did you suffer immediately after the accident?________________________________
____
What effects did you suffer later and when did they begin?_________________________________
____
____
Have you had any of these problems or conditions before (If yes, describe)?________________________
____
____
First Treatment Date:____
Name & phone number of Doctor:____
Were X-rays Taken?____________When:____________________Where:________________________
List Dates Off Work:____
Location and Type of Present Pain:____
____
Name of Insurance Carrier:____
Address of Insurance Carrier:____
Claim #:____
Name of Claim Adjuster:____
Claim Adjuster's Phone Number:____

If this was a Motor Vehicle Accident (MVA):
Direction you were traveling:____
MVA address and closest cross street/exit:____
Make, year and model of the car you were in:____
Make, year and model of the other car:____
Position where you were seated during the MVA:____
Approximately how fast was the car you were in traveling at the time of the MVA?_________________
Approximately how fast was the other car traveling at the time of the MVA?______________________
Were you wearing a seat restraint at the time of the MVA? ________________________________
Where were you looking at the time of the MVA?____
Did you see the other car coming?____
Describe what part(s) of your body, if any, struck the car or its contents:_________________________
____
Did contents of the car change position as a result of the force of the accident (glasses off head, groceries off seat, etc.)? If so, describe:____
____