

ACCIDENTAL INJURY FORM

NAME _____ DATE _____

Date of Accident _____ Time: ___am ___pm Location of Accident _____

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) _____

CHECK SYMPTOMS YOU HAVE NOTIED 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 | | () Loss of Taste | |

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 _____