MOTOR VEHICLE COLLISION REPORT

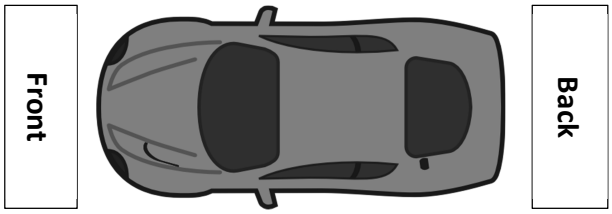
Name:_____ Today's Date:_____ Date of Accident:_____

Briefly describe your accident: _____
_____
_____
_____

Which road were you driving on? _____

In which direction were you headed? _____

What was the nature of your trip? (ex. headed home from work, etc.)
_____



Place a Large "X" to mark where you were sitting in the car. Place a Large "O" to indicate where your vehicle was impacted.

Were you wearing a seatbelt? ____Yes _____No

Was a police report filed? _____Yes _____No

You were the:
_____ driver
_____ front passenger
_____ rear passenger (right)
_____ rear passenger (middle)
_____ rear passenger (left)
_____ other _____

How fast was your vehicle moving? (mph) _____
How fast was the other vehicle moving? _____

Did your head hit any part of the car? ____ Yes ____No
If yes, describe: _____

Did any part of your body hit any part of the care? ____Yes____No
If yes, which part? _____

Was there anyone else in the car with you? ____Yes ____No If yes, have they been examined for injuries? ____Yes ____No

What type of vehicle (make/model) were you in at the time of the accident? _____

What type of vehicle (make/model) impacted your vehicle? _____

Were you aware of the impending collision? ____Yes ____No

Were you facing: ____forward ____right ____left?

What was the damage to your vehicle? _____

What was the damage to the other vehicle? _____

HOSPITAL REPORT

(If you did not visit a hospital or other health care provider after your accident, go to the work status section below.)

Did you go to the hospital after your accident? ____Yes ____No Were you taken by ambulance? ____Yes ____No
When did you go to the hospital? ____Immediately after accident ____1-3 days after accident ____other _____
Were X-rays taken? ____Yes ____No

Have you seen any other healthcare provider **for this accident?** ____Yes ____No If yes, who? _____
What treatment(s) have you received from them and for how long? _____
_____

WORK STATUS REPORT

Were you employed at the time of your accident? ____Yes ____No

Have you been off work because of this accident? ____Yes ____No If yes, for how long? _____

Were you off work because:
____ A doctor took you off work
____ You took yourself off work
____ Your boss took you off work
____ You were fired

Doctor's Signature Confirming Review with Patient: _____