AUTO / WORK RELATED ACCIDENT

one

ABOUT YOU

Today's Date: ___/___/___ File #: _____

Name: _____

twoa

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.
Were you the: ❑Driver ❑Front Passenger ❑Rear Passenger
If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____
Did the police come to the accident site? . .❑ Yes ❑ No
Was a police report filed? . . . . . .❑ Yes ❑ No
Were there any witnesses? . . . . . .❑ Yes ❑ No
Were you wearing your seat belt? . . . . . .❑ Yes ❑ No
Was this vehicle equipped with airbags? . .❑ Yes ❑ No
If yes, did it/they inflate? . . . . . .❑ Yes ❑ No
In relation to the base of your skull, where was the headrest? . . . . . .❑ Above ❑ Below ❑ At base of skull
What did your vehicle impact? ❑ Another vehicle ❑ Other

If other, explain: _____
Did any part of your body strike anything in the vehicle?❑ Yes ❑ No

If yes, please describe: _____

_____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveling?

_____

In which direction were you headed? ❑N ❑S ❑E ❑W

What was the approx. speed of your vehicle? _____
Did the impact to your vehicle come from the:
❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other
During impact, were you facing: ❑Right ❑Left ❑Forward
Were you ❑ aware or ❑ surprised by the impact?
If accident vehicle made impact with another vehicle...
Make and model of that other vehicle? _____

_____

Direction other vehicle was headed? ❑N ❑S ❑E ❑W

Speed of the other vehicle? _____

In your words, please describe the accident: _____

_____

_____

_____

twob

WORK RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.
Was your accident directly related to your work?
❑ Yes ❑ No
Briefly describe the events that occurred just before and during your accident: _____

_____

_____

Give the address where accident occurred: (if other than employer's address) _____

_____

Was anyone else present during your accident?
❑ Yes ❑ No
Did you report your accident to your employer?
❑ Yes ❑ No
What recommendations did your employer make just after your accident? _____

_____

Has this type of accident happened to you before?
❑ Yes ❑ No
To the best of your knowledge, has this accident occurred in your workplace before? . . . . . ❑ Yes ❑ No
In general:
Is your job physically stressful? . . . . . ❑ Yes ❑ No
Is your job mentally stressful?. . . . . ❑ Yes ❑ No
Is your workplace noisy? . . . . . ❑ Yes ❑ No
Have you changed jobs in the last year? ❑ Yes ❑ No

PLEASE CONTINUE ON BACK