# Vehicle Accident Report

Full Name:_____

Date of Accident_____Time of Accident_____AM PM

Were you: (A) Driver (B) Passenger (C) Pedestrian

Were you wearing a seatbelt? (Yes) (No)

Type of Vehicle:
(A) Auto (B) Truck (C) Van (D) Motorcycle (E) Motor home (F) Bicycle

How accident occurred:
(A) Struck by another vehicle (B) Struck another vehicle (C) Struck a stationary object (D) Other

Where was your vehicle hit? (A) Front (B) Rear (C)Right Side (D) Left Side (E) Right Front (F) Left Front (G) Right Rear (H) Left Rear

Where was the other vehicle hit? (A) Front (B) Rear (C)Right Side (D) Left Side (E) Right Front (F) Left Front (G) Right Rear (H) Left Rear

What was your approximate speed?_____MPH

What was the other vehicle's approximate speed?_____MPH

What occurred at the moment of impact? (Circle as many as apply)
(A) Tensed body for impact (B) Neck whipped forward and back (C) Spine torqued and twisted
(D) Thrown over seat (E) Thrown from vehicle (F) Pinned in vehicle (G) Thrown from side to side
(H) Cut and bruised

Did you strike your: (Circle as many as apply)

| | | |
|---|---|---|
| (A) Head | Against the: | Dashboard, Windshield, Steering wheel, Right door, Left door, Seat frame, Unknown object |
| (B) Shoulder (L R) | Against the: | Dashboard, Windshield, Steering wheel, Right door, Left door, Seat frame, Unknown object |
| (C) Arm (L R) | Against the: | Dashboard, Windshield, Steering wheel, Right door, Left door, Seat frame, Unknown object |
| (D) Elbow (L R) | Against the: | Dashboard, Windshield, Steering wheel, Right door, Left door, Seat frame, Unknown object |
| (E) Wrist (L R) | Against the: | Dashboard, Windshield, Steering wheel, Right door, Left door, Seat frame, Unknown object |
| (F) Hip (L R) | Against the: | Dashboard, Windshield, Steering wheel, Right door, Left door, Seat frame, Unknown object |
| (G) Knee (L R) | Against the: | Dashboard, Windshield, Steering wheel, Right door, Left door, Seat frame, Unknown object |
| (H) Ankle (L R) | Against the: | Dashboard, Windshield, Steering wheel, Right door, Left door, Seat frame, Unknown object |

Were you rendered unconscious? (Yes) (No)

Did you receive medical attention at the scene of the accident? (Yes) (No)

Where did you go immediately following the accident? (A) Hospital (B) Home (C) Personal Doctor (D) To this office (E) Resumed activities

Were you: (Circle as many as apply) (A) Shaken (B) Disoriented

Did you have any physical complaints before the accident? (Yes) (No)
If "YES", please describe:

_____
_____
_____
_____
_____

In your own words, please describe your accident:

_____
_____
_____
_____
_____
_____
_____

How did you feel immediately after the accident?

_____
_____
_____
_____
_____

**IMPORTANT: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.**