## **Accident Injury Report**

Date of Accident: Location of Accident	Name:	loday's Date:
Type of Accident:Auto/Traffic Work/On Job At Home Other	All questions must be answered to their fullest.	
Was the accident reported to the Police Department?	Date of Accident: Location of A	Accident
Were you a Driver Passenger Pedestrian?  If passenger, were you sitting in Front Right Rear Left Rear?  What kind of vehicle were you in? Car Truck Motorcycle Other Did your vehicle hit other vehicle(s)? Yes No Estimated speed of your vehicle at impact? MPH Was your vehicle hit by other vehicle(s)? Yes No Estimated speed of other vehicle at impact? MPH What kind of vehicle hit yours? Car Truck Motorcycle Other Was the impact from Front? Right Side? Left Side? Rear?  Were you wearing a seat belt? Yes No Did you strike anything at the time of impact? Yes No If yes, specify: Steering Wheel Dashboard Windshield Side Door/Window Arm Rest Please select part of Body: Chest Chin Knee Shoulder Hand Head Other Describe how the accident happened in your own words:  WEHICLE YOU WERE IN OTHER VEHICLE  Driver: Driver: Adjustor: Phone: Insurance Co.: Adjustor: Phone: Phone: Insurance Co.: In	Type of Accident: Auto/Traffic Work/On	Job At Home Other
If passenger, were you sitting in	Was the accident reported to the Police Department	? Yes No Number of people in your vehicle?
What kind of vehicle were you in?	Were you a Driver Passenger Pede	strian?
What kind of vehicle were you in?	If passenger, were you sitting in Front F	Right Rear Left Rear?
Did your vehicle hit other vehicle(s)?		
Was your vehicle hit by other vehicle(s)?		
What kind of vehicle hit yours?		_
Was the impact from		
Were you wearing a seat belt? Yes No Did you strike anything at the time of impact? Yes No If yes, specify: Steering Wheel Dashboard Windshield Side Door/Window Arm Rest Please select part of Body: Chest Chin Knee Shoulder Hand Head Other Describe how the accident happened in your own words:    VEHICLE YOU WERE IN OTHER VEHICLE		
If yes, specify: Steering Wheel Dashboard Windshield Side Door/Window Arm Rest Please select part of Body: Chest Chin Knee Shoulder Hand Head Other Describe how the accident happened in your own words:    VEHICLE YOU WERE IN OTHER VEHICLE		
Please select part of Body: Chest Chin Knee Shoulder Hand Head Other Describe how the accident happened in your own words:  WEHICLE YOU WERE IN  Driver: Driver:  Auto Insurance Co.: Auto Insurance Co.:  Adjustor: Phone: Phone:  Med Pay Limit: \$  Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Co.:  Have you been contacted by your insurance Company? Yes No  Your Insurance Agent's Name: Phone #:  Have you retained an attorney? Yes No Date attorney retained or to be retained?		
Describe how the accident happened in your own words:  VEHICLE YOU WERE IN  OTHER VEHICLE  Driver:  Auto Insurance Co.:  Adjustor:  Phone:  Phone:  Med Pay Limit: \$  Claim #:  Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Company?	If yes, specify: Steering Wheel Dashboar	rd Windshield Side Door/Window Arm Rest
Driver: Auto Insurance Co.: Adjustor: Phone: Phone: Phone: Claim #:  Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Co.: Have you been contacted by your insurance Company? Yes No Your Insurance Agent's Name: Have you retained an attorney? Yes No Date attorney retained or to be retained?	Please select part of Body: Chest Chin	Knee Shoulder Hand Head Other
Driver:  Auto Insurance Co.:  Adjustor:  Phone:  Med Pay Limit: \$  Claim #:  Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Company?  Yes No  Date Contacted:  Insurance Co.:  Have you been contacted by your insurance Company?  No  Your Insurance Agent's Name:  Phone #:  Have you retained an attorney? Yes No  Date attorney retained or to be retained?	Describe how the accident happened in your own wo	ords:
Driver:  Auto Insurance Co.:  Adjustor:  Phone:  Med Pay Limit: \$  Claim #:  Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Company?  Yes No  Date Contacted:  Insurance Co.:  Have you been contacted by your insurance Company?  No  Your Insurance Agent's Name:  Phone #:  Have you retained an attorney? Yes No  Date attorney retained or to be retained?		
Auto Insurance Co.:  Adjustor:  Phone:  Phone:  Med Pay Limit: \$  Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Company?	VEHICLE YOU WERE IN	OTHER VEHICLE
Adjustor:  Phone:  Phone:  Med Pay Limit: \$  Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Company? Yes No  Date Contacted:  Rep. Name:  Have you been contacted by your insurance Company? Yes No  Your Insurance Agent's Name:  Phone #:  Have you retained an attorney?  Yes No  Date attorney retained or to be retained?	Driver:	Driver:
Phone:  Med Pay Limit: \$  Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Company?	Auto Insurance Co.:	Auto Insurance Co.:
Med Pay Limit: \$ Claim #:  Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Company?	Adjustor:	Adjustor:
Claim #:  Have you been contacted by an adjustor or representative of the opposing Insurance Company? Yes No  Date Contacted: Rep. Name: Insurance Co.:  Have you been contacted by your insurance Company? Yes No  Your Insurance Agent's Name: Phone #:  Have you retained an attorney? Yes No Date attorney retained or to be retained?	Phone:	Phone:
Have you been contacted by an adjustor or representative of the opposing Insurance Company? Yes No  Date Contacted: Rep. Name: Insurance Co.:  Have you been contacted by your insurance Company? Yes No  Your Insurance Agent's Name: Phone #:  Have you retained an attorney? Yes No Date attorney retained or to be retained?	Med Pay Limit: \$	Claim #:
Date Contacted: Rep. Name: Insurance Co.:	Claim #:	
Date Contacted: Rep. Name: Insurance Co.:		
Have you been contacted by your insurance Company? Yes No  Your Insurance Agent's Name: Phone #: Have you retained an attorney? Yes No Date attorney retained or to be retained?	Have you been contacted by an adjustor or represent	tative of the opposing Insurance Company? Yes No
Your Insurance Agent's Name: Phone #: Phone Ph	Date Contacted: Rep. Name:	Insurance Co.:
Have you retained an attorney? Yes No Date attorney retained or to be retained?	Have you been contacted by your insurance Compan	y? Yes No
	Your Insurance Agent's Name:	Phone #:
Attorney's Name: Phone #: Fax #:	Have you retained an attorney? Yes No	Date attorney retained or to be retained?
	Attorney's Name:	Phone #: Fax #:
Full Address:	Full Address:	