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Motor Vehicle Accident Report

Name: ____ Today's Date: ____________________

Date of Accident: ___________ Approximate time of accident: _______ AM ( ) PM ( )

Was it reported to the police? Yes ( ) No ( )

Was a citation issued? Yes ( ) No ( ) To whom? ____

Did this accident occur while on the job? Yes ( ) No ( )

If so, was a workers compensation claim started? Yes ( ) No ( )

Location of accident: ____

Please describe any symptoms felt immediately following the accident:

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Please describe any symptoms felt the following day:

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Approximately how fast were you traveling? ______ mph Other vehicles speed? _______mph

Were you the driver ( ) front passenger ( ) rear passenger ( )

Did the impact to your vehicle come from the front ( ) back ( ) right ( ) left ( )

What did your vehicle impact? Another vehicle ( ) Object ( ) ________________________________

Upon impact, were you thrown Forward ( ) Backward ( ) Right ( ) Left ( )

At the time of impact, were you looking forward ( ) backward ( ) right ( ) left ( )

Upon impact, was there a "blinding" or "explosion" sensation in your head? Yes ( ) No ( )

Were you wearing a seatbelt? Yes ( ) Shoulder harness ( ) Lap harness ( ) No ( )

Were the airbags deployed? Yes ( ) Front ( ) Side ( ) No ( )

Did any part of your body impact the vehicle? Yes ( ) No ( )

If yes, please describe. ____

Were you able to walk directly after the accident? Yes ( ) No ( )

Did you lose consciousness? Yes ( ) No ( ) If yes, do you know how long? ____________________

Did you go to the hospital? Yes ( ) No ( ) If yes, what hospital? ____________________________

Did you go by ambulance? Yes ( ) No ( )

If no, how did you go to the hospital? ____

What was done at the hospital? Exam ( ) Medication administered ( ) X-rays ( )

Describe medications: ____

X-rays of what body parts: ____

Please describe accident including types of vehicles involved, road conditions, and other pertinent information:

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