

# AUTO / WORK RELATED ACCIDENT

1  
one

2a  
twoa

## ABOUT YOU

Today's Date: \_\_\_ / \_\_\_ / \_\_\_ File #: \_\_\_\_\_

Name: \_\_\_\_\_

2b  
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

## 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE CONTINUE ON BACK

