# MOTOR VEHICLE COLLISION REPORT

Name: _____ Date of Accident: _____ Time of Accident: _____ Today's date: _____

Briefly describe your accident: _____

_____

_____

_____

Which road were you driving on? _____

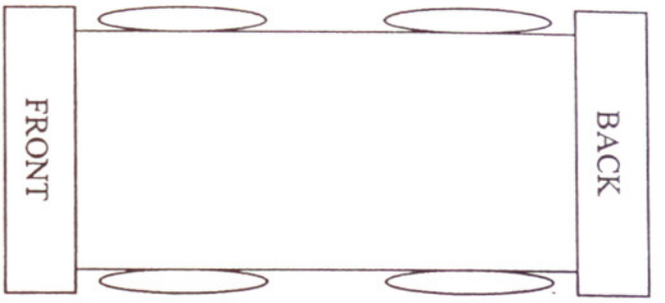
In which direction were you headed? _____

Which road was the other vehicle on? _____

In which direction were they headed? _____

What was the nature of your trip? (i.e. headed home from work, etc.)

_____




**PLACE A LARGE "X" TO MARK WHERE YOU WERE SITTING IN THE CAR. PLACE A LARGE CIRCLE TO INDICATE WHERE YOUR VEHICLE WAS IMPACTED.**

Were you wearing your seatbelt? ☐ YES ☐ NO

Was a police report filed? ☐ Yes ☐ No

You were the:
- ☐ driver
- ☐ front passenger
- ☐ rear passenger (RIGHT)
- ☐ rear passenger (MIDDLE)
- ☐ rear passenger (LEFT)
- ☐ other _____

How fast was your vehicle moving? (mph) _____

How fast was the other vehicle moving? _____

Did your head hit any part of the car? ☐ YES ☐ NO

If yes, describe: _____

Did any part of your body hit any part of the car? ☐YES ☐NO

If so, which part? _____

What type of vehicle (make/model) were you in at the time of the accident? _____

What type of vehicle (make/model) impacted your vehicle? _____

Were you aware of the impending collision? ☐ YES ☐ NO

What was the damage to your vehicle? _____

Were you facing: ☐ straight ahead ☐ left ☐ right

What was the damage to the other vehicle? _____

## HOSPITAL REPORT

**(IF YOU DID NOT VISIT A HOSPITAL OR OTHER HEATH CARE PROVIDER AFTER YOUR ACCIDENT, GO TO THE WORK STATUS SECTION.)**

To which hospital did you go after the accident? _____

Were you taken by ambulance ☐ Yes ☐ No

When did you go? ☐ Immediately after the accident ☐ 1 – 3 days after the accident ☐ other _____

Were X-rays taken? ☐ Yes ☐ No If so, were you lying down when they were taken? ☐ Yes ☐ No

Have you seen any other healthcare providers for this accident? ☐ Yes ☐ No If so, who? _____

What treatment(s) have you received from them, and for how long? _____

_____

## WORK STATUS REPORT

Were you employed at the time of your accident? ☐ Yes ☐ No If so, by whom? _____

Have you been off work because of this accident? ☐ Yes ☐ No If so, how long? _____

Were you off work because:
- ☐ A doctor took you off work — If so, which doctor? _____
- ☐ You took yourself off work
- ☐ Your boss took you off work — If so, who is your boss? _____ Boss's phone #: _____
- ☐ You were fired

Doctor's Signature Confirming Review with Patient: _____