Motor Vehicle Accident Information

Year, make, model of your car____

Year, make, model of other car____

Were you struck from: ❑Behind ❑Right Side ❑Left Side ❑Front

Were you moving? ❑Yes ❑No ❑If Yes, approximate speed__________

Were your breaks applied? ❑Yes ❑No

Type of Transmission? ❑Standard ❑Automatic

Were you the driver or the passenger?_____________________________

Other persons in the car______________________________________

Were you using? ❑Seatbelt ❑Shoulder Harness ❑Nothing

Head restraint on your seat? ❑Yes ❑No

Road Conditions? ❑Wet ❑Dry ❑Snow ❑Ice

Position of head at impact?____

Position of hands at impact?____

Were you aware of the impending collision? ❑Yes ❑No

Did you strike anything inside the car? ❑Yes ❑No

Describe:____

____

Did you feel more than one impact inside the car? ❑Yes ❑No ❑Uncertain

Describe:____

____

Were you unconscious? ❑Yes ❑No

Describe:____

____

Were you dazed? ❑Yes ❑No ❑Uncertain

Where did you after the accident?_______________________________________

If hospital, what was done there?_______________________________________

Was a Police Report made? ❑Yes ❑No

Official estimated property damage? $____________

Signature____ Date_______________