ACCIDENTAL INJURY INFORMATION

IS THIS COMPLAINT DUE TO AN INJURY? YES____ NO____

TYPE OF ACCIDENT:AUTO____ WORK RELATED____ SLIP/FALL____

DATE OF ACCIDENT______________TIME__________AM/PM

DESCRIBE ACCIDENT____

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WAS ACCIDENT REPORT COMPLETED? YES____ NO____

WAS EMPLOYER INFORMED? YES____ NO____

DID THEY RECOMMEND CARE AT THIS OFFICE? YES____ NO____

AUTO ACCIDENT:WERE YOU DRIVER____ PASSENGER____

PEDESTRIAN____ STRUCK FROM BEHIND____ RIGHT SIDE____

LEFT SIDE____

DID YOU NEED HOSPITALIZATION? YES____ NO____

NAME/ADDRESS/PHONE # OF
HOSPITAL____

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WERE YOU TAKEN TO HOSPITAL BY AMBULANCE YES____ NO____

HAVE YOU LOST TIME FROM WORK? YES____ NO____ #OF DAYS____

DATES OUT OF WORK____

IS AN ATTORNEY ADVISING YOU IN THIS CASE? YES____ NO____

NAME/ADDRESS/PHONE# OF ATTORNEY____________________________

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