Personal Accident Report

To be completed by the injured person.

Information about you

Your name____________________ Daytime phone____________ Date of Birth________
Home address ____
Your employer____________________ Your occupation ____________________

Information about the accident

1. Was the accident job-related?______________________________
   If yes, please see your employer about worker's compensation benefits.
2. Where did the accident occur (be as specific as you can) ____________________
3. What was the date and time that the accident occurred? ____________________
4. What was the nature of your injury? ____________________
5. Please describe what happened. ____________________
   ____
   ____
   ____
6. What were you doing when the accident happened?____________________
7. What were the weather conditions when the accident occurred?____________________
8. Did anybody see the accident happen?________ If so, provide their names and phone numbers.
   Name ____________________ Phone ____________
   Name ____________________ Phone ____________
   Name ____________________ Phone ____________

Follow-up information

1. Did you receive medical treatment?____If so, on what date(s)?____________
   Who was the medical provider? ____________________
2. As of today (the date you are completing this form), do you still have any symptoms related to this accident? If so, please describe them. ____________________
   ____
   ____

Your signature ______________________________ Date ____________