one

AUTO / WORK RELATED ACCIDENT



Give the address where accident occurred: (if other than	OILU	A CHARLES			0110	00
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 N Was a police report filed? Yes N Was a police report filed? Yes N Was this vehicle equipped with airbags? Yes N Was this ve	ABOUT	YOU		AUTO RELA	ATED ACCIDE	TN
If a traffic violation was issued, to whom was it issued? Number of people in accident vehicle?	And the Restauration of the Commission of the Commission of Address of the Commission of the Commissio					
Date & Time of Accident: a.m p.m. Was a your accident directly related to your work? Was your accident directly related to your work? Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident: Yes No Briefly describe the events that occurred just before and during your accident:						
Was a police report filed?						
Were you wearing your seat bell? Was this vehicle equipped with airbags? were you wearing your seat bell? was this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No Mas this vehicle equipped with airbags? yes No No No No No No No N	67	1	Was a poli	ice report filed?	🖸 Yes	☐ No
Was this vehicle equipped with airbags? Yes N If yes, did it/they inflate? Above Below At base of sku What did your vehicle impact? Another vehicle Other than employer's address) Was anyone else present during your accident? Yes No What recommendations did your employer make just after your accident? Yes No To the best of your knowledge, has this accident occurred in your works) Yes No In general: Is your job physically stressful? Yes No Is your job mentally stressful? Yes No Is your polar make just after your part of pour make just and the properties of the accident in yes No Is your job mentally stressful? Ye	(1)/6	- Acres				
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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 Yes Yes Yes Yes Yes Yes Yes	□ Y	es 🗆 No 📓	Did any part	of your body strike anythin	ig in the vehicle?☐Yes	□No
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□ Yes □ No Did you report your accident to your employer? □ Yes □ No What recommendations did your employer make just after your accident? □ Yes □ No To the best of your knowledge, has this accident occurred in your workplace before? □ Yes □ No Is your job physically stressful? □ Yes □ No Is your job mentally stressful? □ Yes □ No Is your job mentally stressful? □ Yes □ No Is your job mentally stressful? □ Yes □ No	Was anyone else present during your accident?					
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To the best of your knowledge, has this accident occurred in your workplace before?	, , , , , , , , , , , , , , , , , , , ,	-	Wake an	a moder or that other v	remole:	
To the best of your knowledge, has this accident occurred in your workplace before?			Direction	other vehicle was hea	aded? □N □S □E	□W
in your workplace before?		100	Speed of	the other vehicle?		
Is your job physically stressful? Yes No Is your job mentally stressful? Yes No	in your workplace before? Y		In your wo	ords, please describe t	the accident:	
Is your job mentally stressful? Yes □ No		es 🗆 No 🖁				
is your workplace noisy? Yes UNO	Is your job mentally stressful? □ Y	es 🗆 No				
Have you changed jobs in the last year? ☐ Yes ☐ No						

four

AFTER INJURY

J.,		COLUMN TO SERVICE AND ADDRESS OF THE PARTY O	The same of the sa		
	Did accident render you	unconscious?	Yes Q No		
	If yes, for how long?				
l	Please describe how you felt immediately after the accident:				
l		ion minious and			
l					
l					
l	Have you gone to a Hospital of	or seen any other Docto	r?□ Yes □ No		
l	When did you go? U Just afte				
l	How did you get there? A	mbulance or Privat	e transportation		
ŀ	Name of Hospital and/or	Attending doctor			
l	ivanie oi riospitai anu/oi	Attending doctor.			
١					
١	Was he/she a: ☐ D.C.	□ M.D. □ D.O.	D.D.S.		
l	Describe any treatment	you received:			
l	Describe any treatment	you received			
l					
١	Were X-rays taken?				
l	Was medication prescrib				
1	Have you been able to w				
١	Are your work activities r	estricted as a resul	☐ Yes ☐ No		
l	Indicate I the symptoms	that are a recult of			
		ng DJaw problems	□Nausea		
1	Memory loss Irritability	Arms/Shoulder pain	☐ Back pain		
l	□Headache(s) □Fatigue	□ Numb Hands/Fingers			
ĺ	□Blurred vision □Tension	☐Chest pain	☐ Back stiffness		
l	☐Buzzing in ear ☐Neck pain	☐Shortness of breath	Leg pain		
ĺ	□ Ears ringing □ Neck stiff	☐ Stomach upset	Numb Feet/Toes		
ı	Other				
1	Is your condition getting				
	Indicate your degree of	No Constant C			
1	following activities:	i comort wille p	eriorining the		
1		mfortable Uncomfo	ortable Painful		
l		eve	ortable Painful		
l	Lying on back Lying on side				
d	Lying on stomach				
1	Sitting				
벍	Standing				
1	Stretching				
١	Lovemaking				
l	Walking				
l	Running				
	Sports				
	Lifting				
1	Bending				
1	Kneeling				
1	Pulling				
9	Reaching				
	Have you retained an a				
	If yes, whom:				
1	His/Her Phone #:				

RECOVERY

		t continuing work womplete the following			
How many h	How many hours are in your normal work day?				
		job duties and any ac	ctivities		
which you ar	*	asked to perform.			
Standing	□ Driving	Operating equipme	ent		
□ Sitting	□ Twisting	Work with arms ab	ove head		
□ Walking	□ Crawling	☐ Typing			
☐ Lifting	□ Bending	☐ Stooping			
Other					
What positio	ns can you work	k in with minimum phy	ysical		
effort and for	how long?		□ N/A		
Prior to the in	njury were you	capable of working or	an		
		age? Tyes No			
		o can help you with a			
		☐Yes ☐No			
		ny light duty work you			
		, , , , , , , , , , , , , , , , , , , ,			



ADDITIONAL INSURANCE

	Type of Insurance:
	Co. Name:
-00	Address:
	Phone #:

2nd Insurance Source or Auto Insurance

| Insured's Name: _____ | Claim #: _____

Insured's SS #:_____ D.O.B. / / /
Insured's Employer:_____

Agent's Name:

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

SIGNATURE / / DAYE

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