

# PLAINTIFF'S INFORMATION

DATE OF ACCIDENT: \_\_\_\_\_ TIME: \_\_\_\_\_

## CLIENT

Mr.  Ms. FIRST NAME: \_\_\_\_\_ LAST: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_ WORK TELEPHONE: \_\_\_\_\_

MESSAGE TELEPHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

SS NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

DRIVER'S LICENSE NUMBER: \_\_\_\_\_ STATE: \_\_\_\_\_

## VEHICLES

CAR YEAR: \_\_\_\_\_ MAKE: \_\_\_\_\_ MODEL: \_\_\_\_\_

R/O'S NAME/ADDRESS: \_\_\_\_\_

COLOR: \_\_\_\_\_ L/P NUMBER: \_\_\_\_\_ STATE: \_\_\_\_\_

VEHICLE ID NUMBER: \_\_\_\_\_

EMPLOYERS CAR:  YES  NO VEHICLE DRIVABLE: \_\_\_\_\_

## EMPLOYER

EMPLOYER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ POSITION: \_\_\_\_\_

DATE/HIRE: \_\_\_\_\_ YOUR SUPERVISOR: \_\_\_\_\_

PRESENT SALARY: \_\_\_\_\_ PER  MONTH /  WEEK /  DAY /  HOUR

OFF WORK?  YES /  NO HOW LONG: \_\_\_\_\_

## INSURANCE

COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF INSURED/ADDRESS: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

POLICY OR BOND PERIOD: FROM \_\_\_\_\_ TO \_\_\_\_\_

ADJUSTER'S NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

Fax: \_\_\_\_\_

## COVERAGE

PIP/PD \$ \_\_\_\_\_ MED/PAY \$ \_\_\_\_\_ U.M. \$ \_\_\_\_\_ COL./DED. \$ \_\_\_\_\_

## HEALTH/GROUP

COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

GROUP/PLAN NUMBER: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

## MEDICAL

PARAMEDICS: \_\_\_\_\_ AMBULANCE: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

HOSPITAL'S NAME: \_\_\_\_\_

DOCTORS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ DATE OF ENTRY: \_\_\_\_\_

## DESCRIPTION OF INJURIES

DESCRIPTION: \_\_\_\_\_

BRUISES/CUTS:     YES             NO

DESCRIBE WHERE: \_\_\_\_\_

DOCTOR (S) YOU ARE SEEING: \_\_\_\_\_

TREATING DOCTOR'S ADDRESS: \_\_\_\_\_

PRIOR INJURIES: \_\_\_\_\_

COLL/COMP: \_\_\_\_\_ DATES: \_\_\_\_\_

ATTORNEY'S NAME/ADDRESS: \_\_\_\_\_

SETTLEMENT: \_\_\_\_\_

## WITNESSES

1. NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

2. NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

3. NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

RECORDED STATEMENT:     YES     NO            WITNESS NUMBER: \_\_\_\_\_

DATE OF RECORDED STATEMENT: \_\_\_\_\_

## PASSENGERS

1.  Mr.  Ms. FIRST NAME: \_\_\_\_\_ LAST: \_\_\_\_\_

SEAT LOCATION IN VEHICLE: \_\_\_\_\_ WAS WEARING SEATBELT:  YES  NO

RELATIONSHIP TO THE DRIVER: \_\_\_\_\_

2.  Mr.  Ms. FIRST NAME: \_\_\_\_\_ LAST: \_\_\_\_\_

SEAT LOCATION IN VEHICLE: \_\_\_\_\_ WAS WEARING SEATBELT:  YES  NO

RELATIONSHIP TO THE DRIVER: \_\_\_\_\_

3.  Mr.  Ms. FIRST NAME: \_\_\_\_\_ LAST: \_\_\_\_\_  
SEAT LOCATION IN VEHICLE: \_\_\_\_\_ WAS WEARING SEATBELT:  YES  NO  
RELATIONSHIP TO THE DRIVER: \_\_\_\_\_

## INCIDENT INFORMATION

LOCATION: \_\_\_\_\_ CITY: \_\_\_\_\_  
WEATHER: \_\_\_\_\_  
NUMBER OF VEHICLES: \_\_\_\_ POLICE REPORT:  YES  NO DEPARTMENT: \_\_\_\_\_  
WHERE WERE YOU COMING FROM: \_\_\_\_\_  
WHERE WERE YOU GOING: \_\_\_\_\_  
WHAT DIRECTION WERE YOU TRAVELING: \_\_\_\_\_  
WHAT DIRECTION WAS THE DEFENDANT: \_\_\_\_\_  
HOW MANY LANES WERE THERE: \_\_\_\_\_  
WHAT LANE WERE YOU IN: \_\_\_\_\_  
WHAT SPEED WERE YOU TRAVELING: \_\_\_\_\_  
WHAT SPEED WAS THE DEFENDANT TRAVELING: \_\_\_\_\_  
WERE YOU WEARING YOUR SEATBELT: \_\_\_\_\_  
DID THE DEFENDANT HAVE ANY PASSENGERS:  YES  NO HOW MANY: \_\_\_\_\_  
DID THE DEFENDANT SAY ANYTHING AFTER THE ACCIDENT:  YES  NO  
WHAT: \_\_\_\_\_  
\_\_\_\_\_

DID HE SPEAK ENGLISH:  YES  NO IF NO, WHAT DID HE SPEAK: \_\_\_\_\_  
BEFORE THE COLLISION, HAD YOUR VEHICLE BEEN:  
 MOVING  STOPPED IN TRAFFIC  PARKED  OTHER (Explain) \_\_\_\_\_  
BEFORE THE COLLISION, HAD DEFENDANT'S VEHICLE BEEN:  
 MOVING  STOPPED IN TRAFFIC  PARKED  OTHER (Explain) \_\_\_\_\_  
HOW FAR AWAY WAS DEFENDANT WHEN FIRST SEEN: \_\_\_\_\_  
PART OF YOUR VEHICLE FIRST STRUCK: \_\_\_\_\_  
PART OF DEFENDANT'S VEHICLE FIRST STRUCK: \_\_\_\_\_  
WHO WAS AT FAULT? WHY? \_\_\_\_\_  
\_\_\_\_\_

## DEFENDANT'S INFORMATION

Mr.  Ms. FIRST NAME: \_\_\_\_\_ LAST: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
HOME TELEPHONE: \_\_\_\_\_ WORK TELEPHONE: \_\_\_\_\_  
MESSAGE TELEPHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
SS NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_  
DRIVER'S LICENSE NUMBER: \_\_\_\_\_ STATE: \_\_\_\_\_

## VEHICLES

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COLOR: \_\_\_\_\_ L/P NUMBER: \_\_\_\_\_ STATE: \_\_\_\_\_  
VEHICLE ID NUMBER: \_\_\_\_\_  
EMPLOYERS CAR:  YES  NO VEHICLE DRIVABLE: \_\_\_\_\_

## INSURANCE

COMPANY NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
NAME OF INSURED/ADDRESS: \_\_\_\_\_  
POLICY NUMBER: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_  
POLICY OR BOND PERIOD: FROM \_\_\_\_\_ TO \_\_\_\_\_  
ADJUSTERS NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
Fax: \_\_\_\_\_

## COVERAGE

PI/PD \$ \_\_\_\_\_ MED/PAY \$ \_\_\_\_\_ U.M. \$ \_\_\_\_\_ COL. /DED. \$ \_\_\_\_\_

# DESCRIPTION OF THE ACCIDENT

DESCRIBE ACCIDENT IN DETAIL: \_\_\_\_\_

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DAMAGE OF YOUR CAR: \_\_\_\_\_

DAMAGE OF DEFENDANT'S CAR: \_\_\_\_\_