

# PERSONAL INJURY ACCIDENT REPORT

(To be completed by injured party in complete detail)

Your Name: \_\_\_\_\_

Local / Hotel Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation / Position: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Where did the Accident Happen (Please be Specific) \_\_\_\_\_

\_\_\_\_\_

Please give a detailed description of the Accident (Use back of page if necessary) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did anyone else witness the Accident? YES \_\_\_ NO \_\_\_ If so, who?: Use line(s) below

Name / Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name / Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name / Address: \_\_\_\_\_ Phone: \_\_\_\_\_

What were you doing when the accident happened? \_\_\_\_\_

\_\_\_\_\_

Was any food or drink ingested? \_\_\_\_\_

YES \_\_\_ NO \_\_\_ If so, what type of food/drink was involved? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was first aid administered? \_\_\_\_\_

YES \_\_\_ NO \_\_\_ If so, who provided it and what was provided: \_\_\_\_\_

\_\_\_\_\_

Name and address of your Family Doctor \_\_\_\_\_

\_\_\_\_\_

Name and address of Doctor who treated you for this Injury / Illness \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Use back page if necessary)

# PERSONAL INJURY WITNESS REPORT

(To be completed by witness to injury)

Name of witness: \_\_\_\_\_ (Check one) Passenger \_\_\_\_ Crew \_\_\_\_

Name of person injured: \_\_\_\_\_ Vessel: \_\_\_\_\_

Date of accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_

Exact location of where accident occurred (Please be Specific) \_\_\_\_\_

Please give a detailed description of the Accident (Use back of page if necessary) \_\_\_\_\_

Weather and Sea conditions: \_\_\_\_\_

What were you doing at the time of the accident? \_\_\_\_\_

How far were you from the injured person? \_\_\_\_\_

Give identity of an other witnesses:

Name / Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name / Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name / Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Was first aid administered? \_\_\_\_\_

YES \_\_\_\_ NO \_\_\_\_ If so, who provided it and what was provided: \_\_\_\_\_

Please describe the type of injury sustained: \_\_\_\_\_

Was the injured person take to a physician or hospital? YES \_\_\_\_ NO \_\_\_\_

Name / address of physician or hospital: \_\_\_\_\_

Additional information regarding the accident: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Local hotel address: \_\_\_\_\_ Local Phone: \_\_\_\_\_

Employment position: \_\_\_\_\_ No. of years: \_\_\_\_\_

Work address: \_\_\_\_\_ Work phone: \_\_\_\_\_

(use back page if necessary)