PRIORITY MEDICAL ASSOCIATES

*****PLEASE COMPLETE IF DUE TO A MOTOR VEHICLE COLLISION*****

Date:_____

FIRST NAME:_____LAST NAME:_____

Date of collision: _____ Hour: _____ □AM □PM

Location Road/City: _____

If auto accident, were you □ DRIVER? □ PASSENGER? □ PEDESTRIAN?

If you were the DRIVER, please name any passengers:_____

Describe vehicle you own:_____

Describe any vehicle(s) owned by any members of your family in your current household:

_____

Brief Description of collision: _____

_____

Did you treat with a Doctor or Hospital? Yes No

If yes name: _____

Inpatient or Outpatient

At the time of the collision were you in the course of your employment? □ YES □ NO

Did you lose any wages as a result of your injury? □ YES □ NO

If YES, amount lost to date:_____ Average Weekly Salary:_____

Date disability from work began:_____ Date returned to work:_____

Was your auto struck from: □ Behind? □ Driver's side? □ Passenger side? □ Front?

Other:_____

Have you received or are you eligible for payment under Worker's Compensation of

Unemployment? □ YES □ NO If YES, amount per week:_____