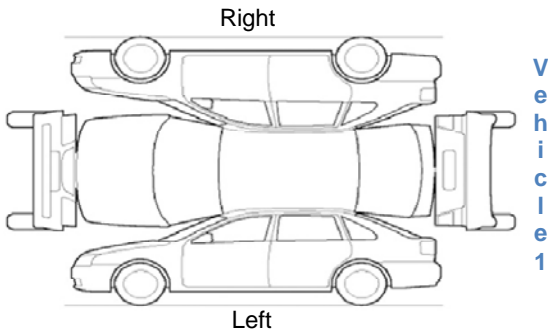


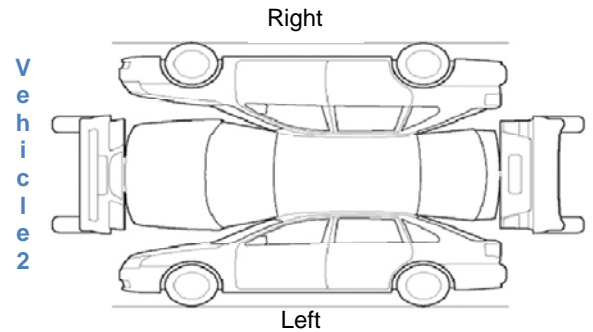


## OREGON AUTO ACCIDENT REPORT FORM

### D I A G R A M   T H E   A C C I D E N T   S C E N E :



Please mark the  
 damaged areas on  
 the corresponding  
 vehicles.



**Check all that apply**

Light Conditions Check one	Type of Incident	Incident occurred on:	Were there flashing lights or warning signs?	What was your vehicle doing in relation to the other vehicle?	If your vehicle was damaged from rocks or debris, where did they come from?	How fast were you and the other driver going?
<input type="checkbox"/> Daylight	<input type="checkbox"/> Sanding	<input type="checkbox"/> Straight road	<input type="checkbox"/> Yes	<input type="checkbox"/> Passing	<input type="checkbox"/> Road surface	Your speed? _____ mph
<input type="checkbox"/> Dawn	<input type="checkbox"/> Pothole	<input type="checkbox"/> Curve	<input type="checkbox"/> No	<input type="checkbox"/> Following	<input type="checkbox"/> Vehicle Tire	
<input type="checkbox"/> Dusk	<input type="checkbox"/> Resurfacing	<input type="checkbox"/> Uphill		<input type="checkbox"/> Parked	<input type="checkbox"/> Load	
<input type="checkbox"/> Other	<input type="checkbox"/> Collision	<input type="checkbox"/> Downhill		<input type="checkbox"/> Approaching from the opposite direction	<input type="checkbox"/> Unknown	Others speed? _____ mph
	<input type="checkbox"/> Other	<input type="checkbox"/> One lane		<input type="checkbox"/> Other	<input type="checkbox"/> Other	
		<input type="checkbox"/> 2 lanes				
		<input type="checkbox"/> 4 lanes				
		<input type="checkbox"/> Other				



Risk Management | SSD  
 1225 Ferry Street SE, U150  
 Salem, OR 97301  
 503-373-7475  
 503-373-7337 fax

E-mail: [risk.management@das.state.or.us](mailto:risk.management@das.state.or.us)

Website: [State of Oregon: Risk Management](http://State of Oregon: Risk Management)

Find this form on the Web at: <http://oregon.gov/XXXXXXX.doc>

## OREGON AUTO ACCIDENT REPORT FORM

**Bodily Injury Questionnaire: IMPORTANT: We are required by federal law to obtain the information in questions 16 through 20. Failure to provide this information will result in delays in resolving your claim. You can find further information at [Medicare Secondary Payer Recovery Contractor \(MSPRC\) - Home](#).**

Bodily Injury Questionnaire	Last Name	First name	Middle initial
	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
	Are you a Medicare beneficiary?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide HICN (required by federal law)
	Is this related to an auto accident? (If no, skip to question 26) <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, where were you seated in vehicle?  <input type="checkbox"/> Driver <input type="checkbox"/> Front right passenger <input type="checkbox"/> Rear right passenger <input type="checkbox"/> Rear left passenger <input type="checkbox"/> Other _____		
	Seatbelt used? <input type="checkbox"/> Yes <input type="checkbox"/> No	What kind? <input type="checkbox"/> Lap <input type="checkbox"/> Shoulder <input type="checkbox"/> None	
	Did the airbag deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Describe your injury:		
	When did you first notice you were injured?		
	Have you sought medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list the medical providers you have seen:	
	Approximate amount of medical costs incurred to date:		
	Is future treatment expected? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:	
	Do you have any prior injuries to the injured body part(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:	
	Do you have any other health issues (such as diabetes, arthritis, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:	
Any other information you would like to provide to us:			

Additional information:

