



Suite 302, 1110 Hamilton St.
 Vancouver, BC, Canada, V6B 2S2
 Phone: 604 984 0040
 Fax: 604 684 0048
 www.personalinjurylawbc.com

ACCIDENT AND INJURY REPORT

Keep this in your car in case of an accident:

1. Fill out this report get as much detail as possible.
2. Do not discuss who was at fault for the accident with anyone except your lawyer.
3. If you are being charged with a traffic offence keep the blue traffic ticket. If the other driver is being charged, find out what the offence is.
4. Find witnesses to the accident. Note the presence of Transit buses or taxis as they may have reported the accident.
5. If you are Injured get medical attention. Injuries may take hours or days to show up.
6. Do not talk to I.C.B.C. until you contact a lawyer, even if you do not intend to use one.
7. You have rights to insurance benefits regardless of who is at fault, including income replacement, medical treatment, car rental and more.
8. Take photographs of the scene and of damage to the vehicles.

Witnesses Pedestrians, Drivers, Passengers

Name:

Address:

Phone:

Name:

Address:

Phone:

Name:

Address:

Phone:

Police Report & Charges

.....

Ticket and Charges or Arrests

.....

Statements by Other Driver

Did the other driver admit:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Fault? | <input type="checkbox"/> In a hurry? |
| <input type="checkbox"/> Seeing you? | <input type="checkbox"/> Lost control? |
| <input type="checkbox"/> Speeding? | <input type="checkbox"/> Apologize? |

Other Notes Things the other driver mentioned

.....

Personal Injuries

Area of injury:

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Lower Back |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Ears |
| <input type="checkbox"/> Hand/Finger | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Groin |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Mid Back | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Shoulders Right or Left | |
| <input type="checkbox"/> Arms Right or Left | |
| <input type="checkbox"/> Knee Right or Left | |
| <input type="checkbox"/> Legs Right or Left | |
| <input type="checkbox"/> Mouth/Jaw/Teeth | |
| <input type="checkbox"/> Other | |
| <input type="checkbox"/> Other | |

Nature of injury:

- | | |
|---|---|
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Stitches |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Drugs |
| <input type="checkbox"/> Burns | |
| <input type="checkbox"/> Collar/Brace/Cast | |
| Symptoms: | |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Loss of Sleep |
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Anxiety/Tension | |
| <input type="checkbox"/> Personality Change | |
| <input type="checkbox"/> Radiating Pain | |

Reduced Range of Motion

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Sharp Pain | |
| <input type="checkbox"/> Constant | <input type="checkbox"/> Periodic |
| Dull Pain | |
| <input type="checkbox"/> Constant | <input type="checkbox"/> Periodic |
| Headaches | |
| <input type="checkbox"/> Constant | <input type="checkbox"/> Periodic |
| <input type="checkbox"/> Activity Related | |

Other Notes Detailed description of injuries

.....

Driver Information

Vehicle No. 1 (you)

Driver's name: _____
 Address: _____
 Home phone: _____
 Work phone: _____
 Dr. license No. _____
 Vehicle plate No. _____
 Vehicle owner name: _____
 Address: _____

Vehicle No. 2

Driver's name: _____
 Address: _____
 Home phone: _____
 Work phone: _____
 Dr. license No. _____
 Vehicle plate No. _____
 Vehicle owner name: _____
 Address: _____

Vehicle No. 3

Driver's name: _____
 Address: _____
 Home phone: _____
 Work phone: _____
 Dr. license No. _____
 Vehicle plate No. _____
 Vehicle owner name: _____
 Address: _____

Accident Scene & Details

Date: _____ Time: _____
 Location: _____

Weather & Lighting Conditions

- | | |
|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Clear | <input type="checkbox"/> Daylight |
| <input type="checkbox"/> Overcast | <input type="checkbox"/> Dusk |
| <input type="checkbox"/> Raining | <input type="checkbox"/> Darkness |
| <input type="checkbox"/> Snow | <input type="checkbox"/> Dry road |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Slippery |
| <input type="checkbox"/> Wet road | <input type="checkbox"/> Fog |

Pre-Collision Factors

- | | |
|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Unsafe speed | <input type="checkbox"/> Swerving |
| <input type="checkbox"/> U-turn | <input type="checkbox"/> Stopped |

- | | |
|---|---|
| <input type="checkbox"/> Backing up | <input type="checkbox"/> Fail to yield |
| <input type="checkbox"/> Follow too close | <input type="checkbox"/> Wrong way |
| <input type="checkbox"/> Illegal move | <input type="checkbox"/> Passing on right or left |
| <input type="checkbox"/> Parked illegally | |
| <input type="checkbox"/> Changing lanes | |

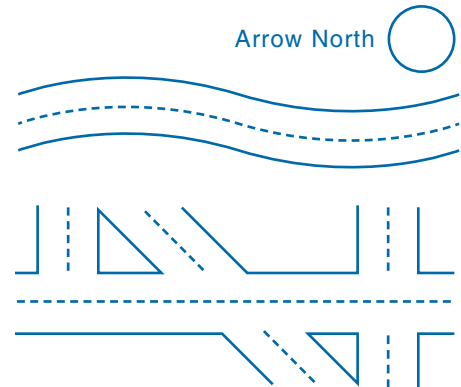
Accident Type

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Rear-ended | <input type="checkbox"/> Sideswipe |
| <input type="checkbox"/> Broadside | <input type="checkbox"/> Vehicle rolled |
| <input type="checkbox"/> Head on | <input type="checkbox"/> _____ |

Description of Accident (Use diagram too)

Diagram

1. Indicate north
2. Show traffic signals & signs
3. Sheet names
4. Distances
5. Lines on road
6. Resting position
7. Direction of travel



Accident Scene Details & Investigation Reminders

Intersection: (Fault)

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Traffic lights - Colour - Red Yellow Green | <input type="checkbox"/> Yield Signs |
| <input type="checkbox"/> Stop Signs | |

Lines on Roadway

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Single Solid | <input type="checkbox"/> Dotted |
| <input type="checkbox"/> Double Solid | <input type="checkbox"/> Left turn lane |

Crosswalk

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Marked | <input type="checkbox"/> Control lights |
| <input type="checkbox"/> Unmarked | |

Number of Lanes

North _____ East _____
 South _____ West _____

One way Street: N S E W

Traffic Speed Limit: _____

Contributing Factors: Alcohol

Safety Equipment:

- | | |
|--|--|
| <input type="checkbox"/> Head rests | <input type="checkbox"/> Lap belt only |
| <input type="checkbox"/> Shoulder & lap belt | |

Pedestrian/Cyclist

- | | |
|--|---|
| <input type="checkbox"/> Dark clothing | <input type="checkbox"/> Running |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Speed |
| <input type="checkbox"/> Jay-walking | <input type="checkbox"/> Cross against signal |

More Information

Vehicle number	1	2	3	4
Traffic Lights? (red, yellow, green)				
Lane travelled? (lane 1 = curb lane)				
Speed travelled				
Headlights on?				
Turn signal on?				
Break lights working?				

Other _____