



**PERSONAL INJURY (TRANSPORT ACCIDENT) INFORMATION SHEET**

**PERSONAL DETAILS**

FULL NAME:.....

ADDRESS:.....

EMAIL ADDRESS: .....

TELEPHONE: .....

DATE OF BIRTH:.....PLACE OF BIRTH.....

INTERPRETER NEEDED: Yes/No LANGUAGE.....

MARITAL STATUS married single de facto divorced widowed

DEPENDANTS/DOB/RELATIONSHIP: .....

.....

.....

**ACCIDENT DETAILS**

PASSENGER / DRIVER / PEDESTRIAN / MOTOR CYCLIST / TRAM / TRAIN / BUS PASSENGER

LICENCE: Yes/No SEAT BELT: Yes/No HELMET: Yes/No

ALCOHOL/DRUGS: Yes/No DETAILS .....

PLACE OF ACCIDENT.....

.....

.....

TRAVELLING FROM/TO:.....

TIME:..... AM/PM DATE: ..... DAY OF WEEK: .....

WEATHER CONDITIONS: WET / DRY LIGHT / DARK LIGHTS ON / OFF

**CIRCUMSTANCES OF ACCIDENT:**.....

.....

.....

.....

.....

PHOTOGRAPHS OF CAR: YES / NO

PHOTOGRAPHS OF SCENE: YES / NO

**WITNESSES**

1.....OF.....PHONE.....

COMMENTS (e.g. view/position? relationship?) .....  
.....

2.....OF.....PHONE.....

COMMENTS (e.g. view/position? relationship?) .....  
.....

REGISTRATION NUMBER OF YOUR MOTOR VEHICLE:..... VICTORIAN Yes / No

REGISTRATION CURRENT ON DATE OF ACCIDENT ..... EXPIRY DATE .....

OTHER PERSONS IN YOUR VEHICLE: YES / NO HOW MANY?

1.....OF..... RELATIONSHIP:.....

2.....OF..... RELATIONSHIP:.....

3.....OF..... RELATIONSHIP:.....

**OTHER VEHICLES**

1. NAME DRIVER: ..... LICENCE NO: .....

ADDRESS: .....

MOBILE: ..... REGN & STATE:.....

INSURANCE DETAILS.....

2. NAME DRIVER: ..... LICENCE NO: .....

ADDRESS: .....

MOBILE: ..... REGN & STATE:.....

INSURANCE DETAILS.....

3. NAME DRIVER: ..... LICENCE NO: .....

ADDRESS: .....

MOBILE: ..... REGN & STATE:.....

INSURANCE DETAILS.....



**POLICE**

ATTEND SCENE: YES / NO..... IF SO DETAILS:.....

.....

IF NOT, REPORTED TO WHICH POLICE STATION:.....

POLICE STATEMENTS: YES / NO (COPIES TO BE PROVIDED)

ANY POLICE CHARGES: .....

.....

**PROPERTY DAMAGE**

CLAIMING ON OWN INSURANCE: YES / NO

INSURER:..... CLAIM NUMBER: .....

**OR DO YOU REQUIRE ASSISTANCE FROM KENYON LEGAL: YES / NO**

**INJURIES**

AMBULANCE YES / NO (HOW TRANSPORTED FROM SCENE): .....

HOSPITAL: YES / NO NAME OF HOSPITAL:..... ADMITTED: YES/NO

INJURIES.....

.....

.....

.....

DID YOU SUFFER LOSS OF CONSCIOUSNESS?.....

WERE YOU TRAPPED IN THE VEHICLE?.....

DID THE FIRE BRIGADE ATTEND THE ACCIDENT SCENE?.....

**MEDICAL TREATMENT**

HOSPITAL DETAILS

HOSPITAL 1..... INPATIENT FOR.....

HOSPITAL 2..... INPATIENT FOR.....

HOSPITAL OUTPATIENT: YES / NO DETAILS: .....



TREATING DOCTORS TO DATE:

1 DOCTOR.....GP/SPECIALIST.....

CLINIC.....PHONE.....

2 DOCTOR.....GP/SPECIALIST.....

CLINIC.....PHONE.....

3 DOCTOR.....GP/SPECIALIST.....

CLINIC.....PHONE.....

4 DOCTOR.....GP/SPECIALIST.....

CLINIC.....PHONE.....

**EMPLOYMENT**

OCCUPATION:.....

EMPLOYER:.....

PERIOD OF EMPLOYMENT.....

WEEKLY EARNINGS GROSS: \$..... ANNUAL SALARY GROSS: \$.....

IF SELF EMPLOYED, BUSINESS / COMPANY NAME:.....

ADDRESS.....

PERIOD & DETAILS OF SELF EMPLOYMENT.....

IF UNEMPLOYED, WERE YOU EMPLOYED IN THE LAST 8 WEEKS / AT LEAST 13 WEEKS IN THE LAST YEAR / AT LEAST 26 WEEKS IN THE LAST 2 YEARS: YES / NO

IF SO LAST EMPLOYMENT DETAILS:.....

ANY TIME OFF WORK? DETAILS:.....

IF RETURNED TO WORK, DATE: .....

WHO PROVIDES MEDICAL CERTIFICATES: .....

