Primary Care Clinic of Kauai

Compassionate, Competent, and Culturally-Sensitive Care

Patient Name:_____

Accident Report

*Today's Date:*_____ *Initial visit Date:*_____

*Address:*_____ *City/State* _____ *Zip Code* _____

DOB: __/__/____ *Social Security #*_____*Occupation*_____

_____

{ } INDUSTRIAL ACCIDENT

Name of Employer :_____ ***Employer's Phone*** _____

Was ***Supervisor Notified*** *of Accident* ***{ } YES { }NO Date:*** __/__/____ ***Time:*** _____ ***am / pm***

Injury Date: __/ __/ ____ ***Where*** *Injury Occurred:*_____

Area of Body Injured:_____

How *did the Injury happen?*_____

_____

{ } NF *(MUST attach Motor vehicle Insurance)*

*Vehicle Owners' Name*_____ *and Phone #*_____

*Was Motor Vehicle Insurance Carrier notified { } YES { } NO Date:*_____ *Time:*_____

*Area of Body Injured:*_____

*How did the Injury Happen:*_____

_____

{ for official use ONLY}

Verified By: _____ *Adjuster Name* _____ *Phone #*_____
Fax # _____

*Insurance Carrier:*_____ _____ *Claim # :*_____

Address: _____ *City/ State :* _____ *Zip Code:* _____

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