

Insurance Co.
 Insuring Company
 Legal Dept., Infl. Hdqrs.

Date of Accident 3-21-75
 Day of Week Saturday
 Hour 11:30 A.M. 3211
 P.M.

INJURED PERSON

Name Michael Address STREET CITY STATE
 (If child, also secure parent's name)
 Married () Single () Phone Number 704-21-25
 Occupation Approximate Age
 Employer Approximate Weight
 Employer's Address Approximate Height
 Was injured wearing glasses?

TYPE OF ACCIDENT make an X in one of the following boxes:

- ☐ slip and fall or other accident inside the store or store entry
☐ parking lot fall or other accident outside store
☐ caused by merchandise or food --- give complete details on reverse
☐ automotive service work
☒ other FAULTY TRAFFIC
 (describe in detail)

Customer's Version of How Accident Happened.

Injury

What injury to person or clothing did you observe?

Damage to his car in the accident "Faulty Traffic" - car was in the street he was driving on and Michael was injured.

Describe first aid rendered aid

Who rendered first aid? aid

If referred to doctor, give name and address Did not seek medical attention
 (See that doctor understands he is to render first aid only and send Authorization for First Aid form with customer) Payor

If customer said would seek own treatment give name and address where treatment would be sought

Did customer indicate further action expected of us? ☐ yes ☐ no.

If yes, what is expected?

Persons who saw or know about Accident - List every one - Attach their statements

(a) Persons (Not Employees) who saw or know about Accident.

(Name) (Address)

(b) Employees who saw Accident

TERRY PAPER 3846 WEST SALES 1.1 JORDAN
 (Name) (Home Address)

(c) Employees who did not see Accident but arrived at scene shortly after.

(Name) (Home Address)

(SEE REVERSE SIDE)

ANSWER ALL QUESTIONS