**OFFICE OF RECOVERY SERVICES ACCIDENT - INJURY QUESTIONNAIRE**

**Complete both pages and return this questionnaire within ten (10) days to The Office of Recovery Services, Team 85, PO Box 45025, Salt Lake City, UT 84145-0025.**

**PLEASE PRINT**

|  |  |  |  |
| --- | --- | --- | --- |
| **PERSONAL INFORMATION** | | | |
| Name of injured person | (Patient Name) | | |
| ORS Case Number | (ORS Case Number) | | |
| Address of injured person |  | | |
| Phone number of injured person |  |  |  |
| **ACCIDENT/INJURY INFORMATION** | | | |
| TYPE OF ACCIDENT | Auto | Work | Other (describe) |
| Date of accident/injury |  |  |  |
| Where accident/injury  occurred (include complete name, address and phone number) |  | | |
| Names of others involved | 1. | | |
|  | 2. | | |
| Explain how the accident or injury occurred | | | |
| Name of Police Department |  | Police Report Number |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURANCE INFORMATION**  **(for auto accident provide all insurance information from all parties;**  **attach additional pages as needed)** | | | |
| Type of Insurance | Auto | Health | Other (describe) |
| Name of insurance |  | | |
| Address |  | | |
| Name of insured person |  | | |
| Phone number |  | Insurance Claim Number |  |
| **EMPLOYER INFORMATION** | | | |
| Name of employer |  | | |
| Address |  | | |
| Phone |  | Employee ID Number |  |
| Worker’s Compensation Claim Filed | Yes No | Worker’s Compensation Claim Number |  |
| Worker’s Compensation Benefits (Describe) |  | | |
| **ATTORNEY INFORMATION** | | | |
| Name |  | | |
| Address |  | | |
| Phone number |  | | |
| **OTHER INFORMATION OR COMMENTS** | | | |
|  | | | |
| Signature |  | | |
| Relationship to injured person |  | | |

**Attach additional pages if needed:**

[Tagline]