Accidental Injury Form ICBC WCB Private Claim	NAME:	DATE:

Adjuster Name: Telephone:	If applicable, lawyer's name and address:
Date of Accident: Hour: a.m. p.m.	Location:
Auto Collision On-the-Job Injury	Other:

If an auto collision, please describe the circumstances:

Did you report the injury to your foreman or employer?			Yes	No
If an auto accident, were you	Driver	Passenger	Pedestrian	
If an auto collision, were you struck from	Behind	Right Side	Left Side	Front
	Auto was parked			
Did your car strike the other(s) involved?			Yes	No
Or did the other car strike yours?			Yes	No
As a result of the accident, were traffic citations issued to you?			Yes	No
…to the driver of the other car?			Yes	No
…to the driver of your car?			Yes	No
Were you wearing a seatbelt?			Yes	No
Did the car have airbags?			Yes	No
If yes, did the airbag(s) open where were you sitting?			Yes	No

List the extent of injuries as you know them:

Did you require post-accident hospitalization? ☐ Yes ☐ No

Please indicate with one of the following codes:

1 – PAST SYMPTOM **2 – PRESENT SYMPTOM**

___ headache	___ dizziness	___ depression	___ fatigue
___ stomach upset	___ light bothers eyes	___ buzzing in ears	___ diarrhea
___ neck pain	___ head is heavy	___ memory loss	___ feet cold
___ neck stiff	___ pins/needles in arms	___ ears ring	___ hands cold
___ fainting	___ sleeping problems	___ loss of balance	___ back pain
___ face flushed	___ pins/needles in legs	___ constipation	___ tension
___ nervousness	___ numbness in fingers	___ loss of smell	___ fever
___ irritability	___ numbness in toes	___ loss of taste	___ chest pain
___ cold sweats	___ shortness of breath	___ nausea	

Other Symptoms:

Time off work? List dates: