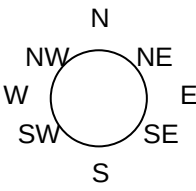


A. CRASH DATA INFORMATION		
IF POSSIBLE, OBTAIN THIS INFORMATION FROM THE DRIVER		
<p>A1. Travel direction (circle appropriate direction on the compass)</p>		<p>If direction not known, what destination were they coming from or going to?</p> <p>_____</p> <p>_____</p>
<p>A2. Road condition (Mark only one which best applies)</p>	<input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Snow <input type="checkbox"/> Slush <input type="checkbox"/> Ice/Frost <input type="checkbox"/> Water (Standing, Moving) <input type="checkbox"/> Sand <input type="checkbox"/> Dirt, Mud or Gravel <input type="checkbox"/> Oil <input type="checkbox"/> Unknown <input type="checkbox"/> Other (describe)	
<p>A3. Weather conditions (Mark all that apply)</p>	<input type="checkbox"/> Fog, Smog, Smoke <input type="checkbox"/> Rain <input type="checkbox"/> Sleet/Hail <input type="checkbox"/> Snow <input type="checkbox"/> Blowing Snow <input type="checkbox"/> Crosswinds <input type="checkbox"/> Blowing Sand, Soil, Dirt <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Unknown <input type="checkbox"/> Other (describe)	
<p>A4. Presence of sign or signal (Mark all that apply)</p>	<input type="checkbox"/> None (SKIP TO A6) <input type="checkbox"/> Unknown (SKIP TO A6) <input type="checkbox"/> Traffic control signal (includes flashing beacons, lane control signals, and green/amber/ red signal) <input type="checkbox"/> Stop sign <input type="checkbox"/> Yield sign <input type="checkbox"/> School zone sign <input type="checkbox"/> Other (describe)	
<p>A5. If sign or signal present, was it functioning properly?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No (describe problem) <input type="checkbox"/> Unknown	
<p>A6. Pre-crash travel lane (Lane 1 is the right curb lane)</p>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
<p>A7. Speed before impact?</p>	<p>_____ mph <input type="checkbox"/> Stopped <input type="checkbox"/> Unknown</p>	
<p>A8. Before impact, intending to... (Mark all that apply)</p>	<input type="checkbox"/> Go straight <input type="checkbox"/> Stop <input type="checkbox"/> Turn left <input type="checkbox"/> Turn right <input type="checkbox"/> Slow down <input type="checkbox"/> Accelerate <input type="checkbox"/> Back up <input type="checkbox"/> Negotiating a curve <input type="checkbox"/> Change lanes to right <input type="checkbox"/> Change lanes to left <input type="checkbox"/> Unknown <input type="checkbox"/> Other (describe)	
<p>A9. Was there loss of control? If so, due to what?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes, due to mechanical problem (describe) <input type="checkbox"/> Yes, due to weather (describe) <input type="checkbox"/> Unknown	
<p>A10. Avoidance actions (Mark all that apply)</p>	<input type="checkbox"/> None <input type="checkbox"/> Braking with lock-up <input type="checkbox"/> Braking without lock-up <input type="checkbox"/> Releasing brakes <input type="checkbox"/> Accelerating <input type="checkbox"/> Steering left <input type="checkbox"/> Steering right <input type="checkbox"/> Unknown <input type="checkbox"/> Other (describe)	
<p>A11. Location of vehicle at impact</p>	<input type="checkbox"/> Original travel lane <input type="checkbox"/> Different travel lane (describe) <input type="checkbox"/> In intersection <input type="checkbox"/> Off roadway to right <input type="checkbox"/> Off roadway to left <input type="checkbox"/> Unknown <input type="checkbox"/> Other (describe)	
<p>Use this space for any additional notes about the pre-crash and impact.</p>		

B. ROLLOVER INFORMATION	
B1. Did this vehicle roll over during the crash?	<input type="checkbox"/> No (SKIP TO SECTION C BELOW) <input type="checkbox"/> Unknown (SKIP TO SECTION C BELOW) <input type="checkbox"/> Yes (CONTINUE)
B2. Rollover began where?	<input type="checkbox"/> On roadway <input type="checkbox"/> On shoulder <input type="checkbox"/> On roadside or median <input type="checkbox"/> Unknown
B3. Cause of rollover	<input type="checkbox"/> Other vehicle (describe which one) <input type="checkbox"/> Contact with object (describe) <input type="checkbox"/> Other cause (describe) <input type="checkbox"/> Unknown
B4. Direction of vehicle roll	<input type="checkbox"/> Toward the right (passenger side) <input type="checkbox"/> Toward the left (driver side) <input type="checkbox"/> End-over-end <input type="checkbox"/> Unknown
B5. Number of turns	_____ Number of QUARTER TURNS <input type="checkbox"/> Unknown OR _____ Number of COMPLETE TURNS
B6. Plane in contact with ground at final rest	<input type="checkbox"/> Left side <input type="checkbox"/> Right side <input type="checkbox"/> Top <input type="checkbox"/> Wheels <input type="checkbox"/> Unknown
C. FIRE INFORMATION	
C1. Did this vehicle experience a fire?	<input type="checkbox"/> No (SKIP TO SECTION D BELOW) <input type="checkbox"/> Unknown (SKIP TO SECTION D BELOW) <input type="checkbox"/> Yes (CONTINUE)
C2. Fire or smoke first seen	<input type="checkbox"/> Under the hood <input type="checkbox"/> In the trunk/cargo area <input type="checkbox"/> Behind the instrument panel <input type="checkbox"/> Under the vehicle <input type="checkbox"/> In the passenger compartment <input type="checkbox"/> From other involved vehicle <input type="checkbox"/> Unknown
Describe any additional rollover or fire information here:	
D. DRIVER ACTIONS	
D1. Prior to the crash, was the driver doing any of the following? (Mark all that apply)	<input type="checkbox"/> Dealing with a child/passenger inside the car <input type="checkbox"/> Looking for something inside the car <input type="checkbox"/> Distracted by another occupant <input type="checkbox"/> Adjusting an internal control, such as radio, climate, opening glove compartment <input type="checkbox"/> Using a handheld device such as a cell phone or electronic organizer <input type="checkbox"/> Eating or drinking <input type="checkbox"/> Smoking <input type="checkbox"/> Sleepy or fell asleep <input type="checkbox"/> Looking for something outside of the car (street sign, building, etc.) <input type="checkbox"/> Having personal thoughts/daydreaming/thinking <input type="checkbox"/> Distracted by pedestrian / animal / object outside the car <input type="checkbox"/> Other (describe) <input type="checkbox"/> Unknown
Describe any additional driver actions just before crash:	

E. ADDITIONAL VEHICLE INFORMATION	
E1. Year, make, model	Year: _____ Make: _____ Model: _____
E2. Vehicle mileage	_____ miles <input type="checkbox"/> Unknown
E3. Was there any pre-existing damage to the vehicle, or damage caused by rescue personnel?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (describe)
E4. Did any door(s) or hatch open during the crash? (Mark all that apply)	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> Left front <input type="checkbox"/> Right front <input type="checkbox"/> Left rear <input type="checkbox"/> Right rear <input type="checkbox"/> Hatch <input type="checkbox"/> Other (describe)
E5. Did any windows break during the crash? (Mark all that apply)	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> Windshield <input type="checkbox"/> Left front <input type="checkbox"/> Right front <input type="checkbox"/> Left rear <input type="checkbox"/> Right rear <input type="checkbox"/> Left rear 2 <input type="checkbox"/> Right rear 2 <input type="checkbox"/> BL <input type="checkbox"/> LBL <input type="checkbox"/> RBL <input type="checkbox"/> Roof <input type="checkbox"/> Other <input type="checkbox"/> Unknown
E6. Window pre-crash status (Write in appropriate letter for all windows) F=Fixed, O=Open, P=Partially open, C=Closed, U=Unknown	___ Left front ___ Right front ___ Left rear ___ Right rear ___ Left rear 2 ___ Right rear 2 ___ BL ___ LBL ___ RBL ___ Roof ___ Other
E7. Cargo in the vehicle (Describe any objects in the vehicle or trunk weighing over 2 pounds)	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (describe) Approximate weight of cargo: _____ pounds
E8. Location of vehicle	<i>If vehicle has not yet been inspected, mark box below and record current location and contact person on the cover sheet. Do not record it here.</i> <input type="checkbox"/> Vehicle inspected <input type="checkbox"/> Vehicle location recorded on cover sheet <input type="checkbox"/> Insurance information recorded on cover sheet
Ask questions E9 – E11 for 2010 and newer vehicles only	
E9. Is the vehicle equipped with any of the following features? (Mark all that apply)	<input type="checkbox"/> LDW with Lane Keeping <input type="checkbox"/> Blind Spot Detection <input type="checkbox"/> LDW without Lane Keeping <input type="checkbox"/> Daytime Running Light <input type="checkbox"/> FCW with Auto Braking <input type="checkbox"/> Assisted Braking <input type="checkbox"/> FCW without Auto Braking <input type="checkbox"/> Automatic Crash Notification
E10. Were any of the above features disabled at the time of the crash?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (describe)
E11. Did occupants see, hear, or feel anything to indicate activation of the above features?	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (describe)

F. OCCUPANT DATA QUESTIONS

F1. Including the driver, how many people were in the vehicle at the time of the crash? _____

Please respond to each question for the driver and up to three additional occupants

	DRIVER	OCCUPANT 2	OCCUPANT 3	OCCUPANT 4
F2. Seating position (Circle appropriate position of each occupant) If "Other" location, specify _____	Front	Front	Front	Front
	1 2 3	1 2 3	1 2 3	1 2 3
	4 5 6	4 5 6	4 5 6	4 5 6
	7 8 9	7 8 9	7 8 9	7 8 9
	Other	Other	Other	Other

F3. Sex 1. Male 2. Female, not pregnant 3. Female, Pregnant, # of months 4. Female, unknown if pregnant	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	<input type="checkbox"/> 3 _____	<input type="checkbox"/> 3 _____	<input type="checkbox"/> 3 _____	<input type="checkbox"/> 3 _____
	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4

If pregnant, indicate any crash related fetal complications on the mannequin page

F4. Height, Weight, Age 1. Height (Feet and inches) 2. Weight (Pounds) 3. Age (Years)	1. _____	1. _____	1. _____	1. _____
	2. _____	2. _____	2. _____	2. _____
	3. _____	3. _____	3. _____	3. _____

F5. Race 1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 6. Other (specify) 7. Unknown	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____
	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7

F6. Ethnicity 1. Not of Hispanic origin 2. Of Hispanic origin 3. Unknown if of Hispanic origin	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3

F7. Feet/hands/arms just prior to impact	<i>Indicate all letters that apply and further describe as needed</i>			
	<p>FEET/LEGS</p> <p>A. Both feet on floor or foot controls</p> <p>B. One or both feet on dash</p> <p>C. One or both feet on seat</p> <p>D. Legs crossed</p> <p>E. Other (describe)</p> <p>F. Unknown</p>	<p>HANDS/ARMS</p> <p>G. Both hands on steering wheel (specify o'clock positions)</p> <p>H. One on wheel, other adjusting control (describe)</p> <p>I. Hand(s) doing other activity (describe)</p> <p>J. Bracing with one/both hands (describe)</p> <p>K. Hands on lap</p> <p>L. One or both arms out window</p> <p>M. Other (describe)</p> <p>N. Unknown</p>		

F8. Occupant wearing glasses, contacts, or have any objects in mouth/hand? (Mark if yes and describe)	<input type="checkbox"/> Yes (Describe)	<input type="checkbox"/> Yes (Describe)	<input type="checkbox"/> Yes (Describe)	<input type="checkbox"/> Yes (Describe)
	<input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> No <input type="checkbox"/> Unk

G. RESTRAINT INFORMATION

	DRIVER	OCCUPANT 2	OCCUPANT 3	OCCUPANT 4
G1. Was this occupant in a child safety seat? <i>(If yes, complete separate Child Safety Seat Form)</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
G2. Type of seat belt available 1. Lap belt 2. Shoulder belt 3. Lap and shoulder belt 4. Not available (describe reason) 5. Unknown	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____ <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____ <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____ <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____ <input type="checkbox"/> 5
G3. Occupant wearing any seatbelt? 1. Yes 2. No 3. Unknown	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
G4. If seat belt worn, what was the type? 1. Lap belt 2. Shoulder belt 3. Lap and shoulder belt 4. Unknown	(Skip if seat belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(Skip if seat belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(Skip if seat belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	(Skip if seat belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
G5. If lap belt used, how was it positioned? 1. Low across hips 2. Across abdomen 3. Used to install Child Safety Seat 4. Other position (describe) 5. Unknown position	(Skip if lap belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____ <input type="checkbox"/> 5	(Skip if lap belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____ <input type="checkbox"/> 5	(Skip if lap belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____ <input type="checkbox"/> 5	(Skip if lap belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____ <input type="checkbox"/> 5
G6. If lap belt used, was it snug or was there extra slack room? 1. Snug 2. Extra slack room 3. Unknown	(Skip if lap belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	(Skip if lap belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	(Skip if lap belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	(Skip if lap belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
G7. If shoulder belt used, how was it positioned? 1. Across collarbone & over shoulder 2. Resting on neck 3. On edge of shoulder 4. Under arm 5. Behind back or seat 6. Used to install Child Safety Seat 7. Other position (describe) 8. Unknown position	(Skip if shoulder belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 _____ <input type="checkbox"/> 8	(Skip if shoulder belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 _____ <input type="checkbox"/> 8	(Skip if shoulder belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 _____ <input type="checkbox"/> 8	(Skip if shoulder belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 _____ <input type="checkbox"/> 8
G8. If shoulder belt used, was it snug or was there extra slack room? 1. Snug 2. Extra slack room 3. Unknown	(Skip if shoulder belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	(Skip if shoulder belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	(Skip if shoulder belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	(Skip if shoulder belt not worn) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

Describe any breaks, tears, or failures to any of the seat belts:

G. RESTRAINT INFORMATION (continued)

	DRIVER		OCCUPANT 2		OCCUPANT 3		OCCUPANT 4	
G9. Was there an upper anchorage adjustment for seat belt? <i>(If yes, indicate position)</i> 1. No 2. Yes, Full up 3. Yes, Mid position 4. Yes, Full down 5. Unknown	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
G10. Was a seat belt positioning device present? <i>(Such as a shoulder belt adjuster)</i> 1. No 2. Yes (describe type of device) 3. Unknown	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	<input type="checkbox"/> 2 _____	<input type="checkbox"/> 2 _____	<input type="checkbox"/> 2 _____	<input type="checkbox"/> 2 _____	<input type="checkbox"/> 2 _____	<input type="checkbox"/> 2 _____	<input type="checkbox"/> 2 _____	<input type="checkbox"/> 2 _____
	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
G11. If "yes" to above, was the belt positioning device in use during crash? 1. No 2. Yes 3. Unknown	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
G12. Seating posture 1. Upright - back against seat back 2. Leaning forward 3. Leaning to the left 4. Leaning to the right 5. Lying on or across seat 6. Other (describe) 7. Unknown	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____	<input type="checkbox"/> 6 _____
	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7
G13. Adjustable seat <u>track</u> position prior to impact 1. No adjustable seat track 2. Seat all the way forward 3. Between forward and middle 4. At middle position 5. Between middle and rear position 6. Seat all the way rearward 7. Unknown	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7
G14. Adjustable seat <u>back</u> position pre-impact and post- impact	<u>PRE</u>	<u>POST</u>	<u>PRE</u>	<u>POST</u>	<u>PRE</u>	<u>POST</u>	<u>PRE</u>	<u>POST</u>
	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7

G15. Adjustable pedal presence/position				
1. No adjustable pedals	<input type="checkbox"/>	1		
2. Full forward (toward toepan)	<input type="checkbox"/>	2		
3. Mid position	<input type="checkbox"/>	3		
4. Full rearward (toward driver)	<input type="checkbox"/>	4		
5. Position unknown	<input type="checkbox"/>	5		
6. Unknown if present	<input type="checkbox"/>	6		

H. EJECTION, ENTRAPMENT, MOBILITY INFORMATION

	DRIVER	OCCUPANT 2	OCCUPANT 3	OCCUPANT 4
H1. Any part of body thrown outside the vehicle during the crash? 1. No 2. Unknown 3. Yes (describe parts of body ejected and what area of vehicle was involved)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)
H2. Was occupant physically pinned in the vehicle? 1. No 2. Unknown 3. Yes (describe entrapment)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)
H3. Was occupant trapped (but not pinned) in the vehicle? 1. No 2. Unknown 3. Yes (describe entrapment)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (describe)
H4. How did occupant exit the vehicle? 1. Fatal before removed 2. Removed while unconscious or not oriented to time or place 3. Removed due to perceived serious injuries 4. Exited with some assistance 5. Exited under own power 6. Fully ejected 7. Removed for other reasons (specify) 8. Unknown	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8

Further describe any ejection, entrapment or mobility information here.

I. AIR BAG INFORMATION

11. Is this vehicle equipped with an air bag? (Mark yes if it had ever been equipped with an air bag)

- Yes (CONTINUE) No (SKIP TO SECTION J) Unknown (SKIP TO SECTION J)

12. Air bag information
(even if no passenger in that seat)

Was this air bag present?

Did it deploy in the crash?

Was there prior service on it?

Was it the original air bag, a replacement air bag, or unknown?

A. Driver air bags

1. Steering wheel hub
2. Bottom inst. panel
3. Seat back
4. Door
5. Roof side rail
6. Other _____

Present?

- 1
- 2
- 3
- 4
- 5
- 6

Deployed?

- 1
- 2
- 3 UNK
- 4
- 5
- 6

Prior service?

- 1
- 2
- 3 UNK
- 4
- 5
- 6

Original Replacement

- | | |
|----------------------------|---|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 2 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 3 UNK |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 4 <input type="checkbox"/> |
| <input type="checkbox"/> 5 | <input type="checkbox"/> 5 |
| <input type="checkbox"/> 6 | <input type="checkbox"/> 6 |

B. Front right air bags

1. Top instrument panel
2. Mid instrument panel
3. Bottom inst. panel
4. Seat back
5. Door
6. Roof side rail
7. Other _____

Present?

- 1
- 2
- 3
- 4
- 5
- 6
- 7

Deployed?

- 1
- 2
- 3 UNK
- 4
- 5
- 6
- 7

Prior service?

- 1
- 2
- 3 UNK
- 4
- 5
- 6
- 7

Original Replacement

- | | |
|----------------------------|---|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 2 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 3 UNK |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 4 <input type="checkbox"/> |
| <input type="checkbox"/> 5 | <input type="checkbox"/> 5 |
| <input type="checkbox"/> 6 | <input type="checkbox"/> 6 |
| <input type="checkbox"/> 7 | <input type="checkbox"/> 7 |

C. Second row left

1. Seat back
2. Door
3. Roof side rail
4. Other _____

Present?

- 1
- 2
- 3
- 4

Deployed?

- 1
- 2 UNK
- 3
- 4

Prior service?

- 1
- 2 UNK
- 3
- 4

Original Replacement

- | | |
|----------------------------|---|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 2 UNK |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 3 <input type="checkbox"/> |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |

D. Second row right

1. Seat back
2. Door
3. Roof side rail
4. Other _____

Present?

- 1
- 2
- 3
- 4

Deployed?

- 1
- 2 UNK
- 3
- 4

Prior service?

- 1
- 2 UNK
- 3
- 4

Original Replacement

- | | |
|----------------------------|---|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 2 UNK |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 3 <input type="checkbox"/> |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |

E. Third row left

1. Seat back
2. Door
3. Roof side rail
4. Other _____

Present?

- 1
- 2
- 3
- 4

Deployed?

- 1
- 2 UNK
- 3
- 4

Prior service?

- 1
- 2 UNK
- 3
- 4

Original Replacement

- | | |
|----------------------------|---|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 2 UNK |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 3 <input type="checkbox"/> |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |

F. Third row right

1. Seat back
2. Door
3. Roof side rail
4. Other _____

Present?

- 1
- 2
- 3
- 4

Deployed?

- 1
- 2 UNK
- 3
- 4

Prior service?

- 1
- 2 UNK
- 3
- 4

Original Replacement

- | | |
|----------------------------|---|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 2 UNK |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 3 <input type="checkbox"/> |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |

13. Has this vehicle:

- Been in previous crashes? No Unknown Yes (# of previous crashes _____)
- If yes, did the airbag(s) deploy? No Unknown Yes (describe below)
- If yes, were airbag(s) reinstalled? No Unknown Yes (describe below)

14. Is this vehicle equipped with an air bag shut off switch?

- No Unknown Yes – Auto Position Yes – Off Position Yes – Unknown Position

Describe any further air bag information or the presence of retrofitted air bags or shut off switches below.

J. INJURY INFORMATION				
	DRIVER	OCCUPANT 2	OCCUPANT 3	OCCUPANT 4
J1. Was occupant injured? 1. Yes 2. No 3. Unknown	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
J2. Was occupant transported directly from crash scene for treatment? 1. Yes 2. No 3. Unknown	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
J3. Did occupant receive any medical treatment? 1. No 2. EMS at scene 3. Hospital 4. Medical clinic 5. Doctor's office 6. Treated by self 7. Unknown	If 2, 3, 4, or 5 is selected, record medical facility information on the cover page.			
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7
J4. IF HOSPITAL MARKED IN J3, Which describes occupant's treatment level? 1. Treated and released from emergency room 2. Admitted to hospital (indicate number of days) 3. Unknown	<input type="checkbox"/> 1 <input type="checkbox"/> 2 _____ <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 _____ <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 _____ <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 _____ <input type="checkbox"/> 3
J5. Did occupant receive any follow-up treatment? 1. Yes 2. No 3. Unknown	If yes for any occupant(s) below, indicate additional treatment facilities on the cover page <u>and</u> any additional injuries diagnosed on the mannequins.			
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
J6. Did occupant miss any days of work or school as a result of the crash? (Includes full-time college student) 1. Yes (write in number of days) 2. No 3. Not working prior to crash 4. Unknown	<input type="checkbox"/> 1 _____ <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 _____ <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 _____ <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 _____ <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
J7. Need appointment to sign medical release? (If yes, record date and logistics on cover sheet) 1. Yes 2. No 3. Unknown	If yes for any occupant(s) below, record the date, time and place to sign the medical release on the cover page.			
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

K. INDIVIDUAL INJURY DESCRIPTION

K1. Identify which occupant is being reported on here:

PSU Number _____ Case Number—Stratum _____ Vehicle Number _____ Occupant Number _____

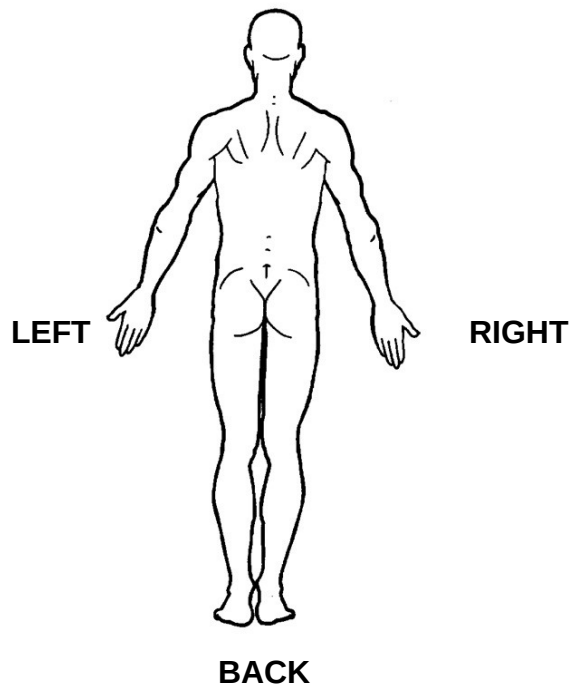
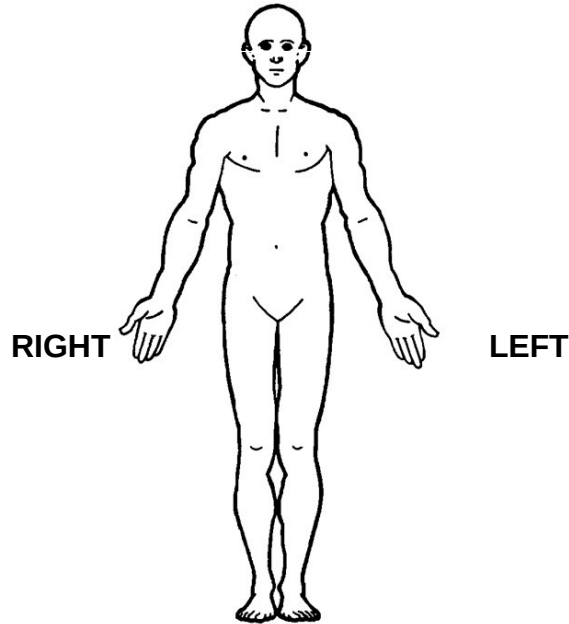
K2. Did occupant have any of the following injuries?

- Cuts Abrasions Bruises Fractures Head/skull/brain Internal Sprains/strains Other

Annotate Injury, Source, Body Region, and Aspect on the mannequins.

FRONT

No Injuries



K. INDIVIDUAL INJURY DESCRIPTION

K3. Identify which occupant is being reported on here:

PSU Number _____ Case Number—Stratum _____ Vehicle Number _____ Occupant Number _____

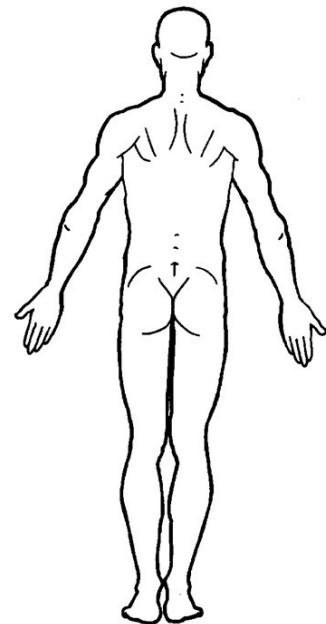
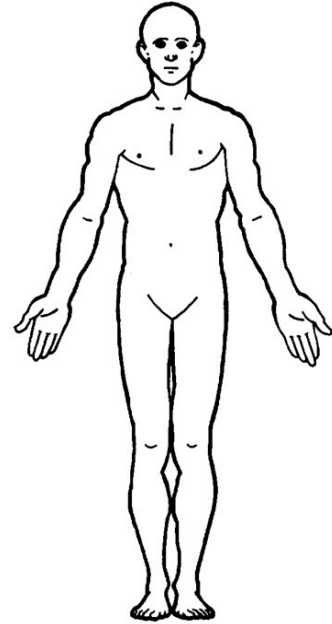
K4. Did occupant have any of the following injuries?

- Cuts Abrasions Bruises Fractures Head/skull/brain Internal Sprains/strains Other

Annotate Injury, Source, Body Region, and Aspect on the mannequins.

No Injuries

FRONT



BACK

K. INDIVIDUAL INJURY DESCRIPTION

K5. Identify which occupant is being reported on here:

PSU Number ____ Case Number—Stratum ____ Vehicle Number ____ Occupant Number ____

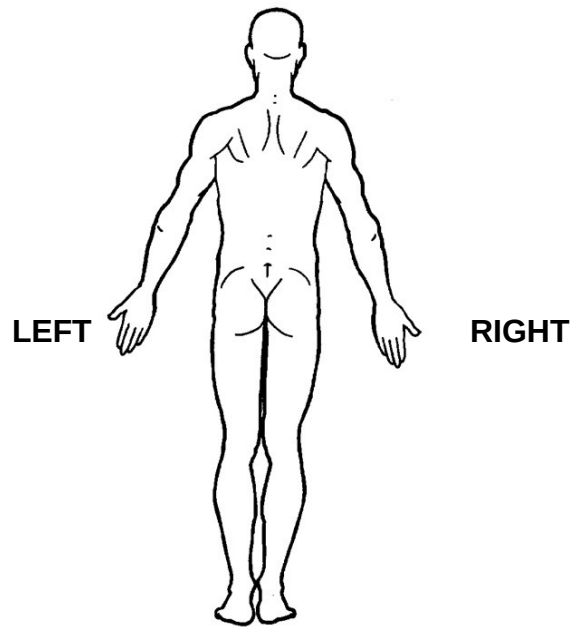
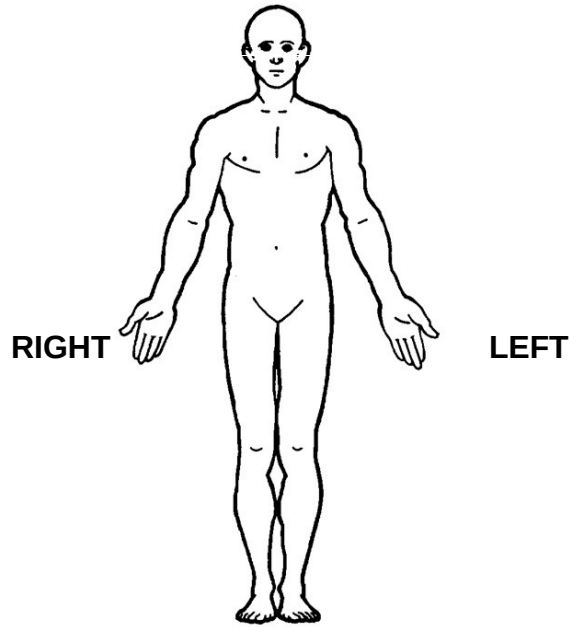
K6. Did occupant have any of the following injuries?

Cuts Abrasions Bruises Fractures Head/skull/brain Internal Sprains/strains
Other

Annotate Injury, Source, Body Region, and Aspect on the mannequins.

FRONT

No Injuries



BACK

K. INDIVIDUAL INJURY DESCRIPTION

K7. Identify which occupant is being reported on here:

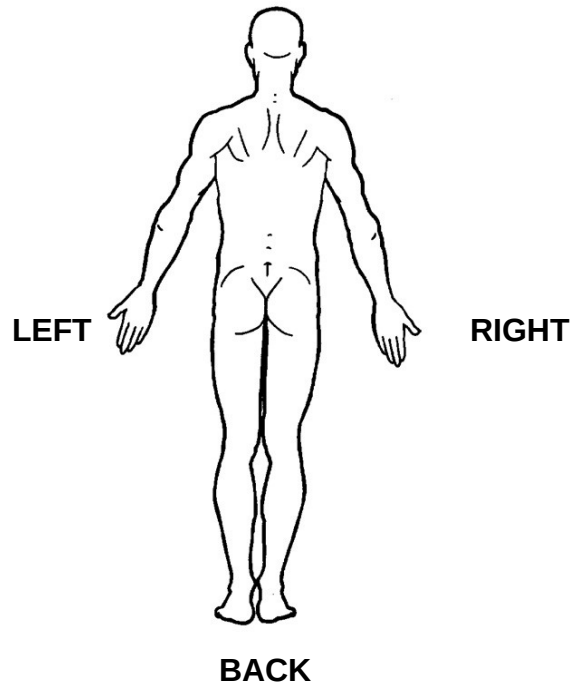
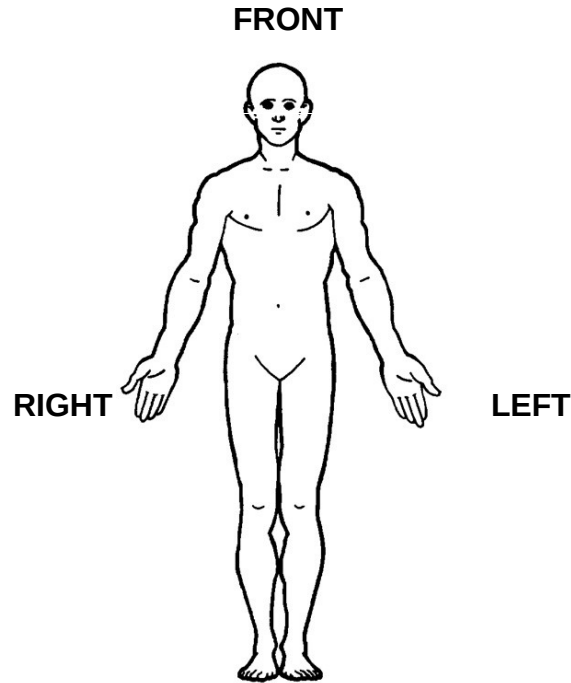
PSU Number ____ Case Number—Stratum ____ Vehicle Number ____ Occupant Number ____

K8. Did occupant have any of the following injuries?

- Cuts Abrasions Bruises Fractures Head/skull/brain Internal Sprains/strains Other

Annotate Injury, Source, Body Region, and Aspect on the mannequins.

No Injuries



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