

CISS LOGO
HERE

Interview Form Cover Sheet

PSU Number __ __

Case Number __ __ __ __

Vehicle Number __ __

Interviewee(s) Role or Name(s):

Phone Number: () _____

Occupant #	Name	Date of Birth	Medical Facility <i>(If multiple treatment locations – list all)</i>	Discharge Date(s)
1				
2				
3				
4				
5				
6				

Date, Time and Place
to have medical release signed:

Other identifying information:

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INTERVIEW FORM (A)

<p>1. Primary Sampling Unit Number ___ ___</p> <p>2. Case Number ___ ___ ___ ___</p> <p>3. Vehicle Number ___ ___</p>	<p>Interviewee(s) Role: _____</p> <p>_____</p>
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DRIVER OR OCCUPANT DESCRIPTION AND DIAGRAM OF CRASH EVENTS

Use this space to diagram the interviewee's crash trajectory in relationship to identifiable objects in the environment. Indicate which direction is north on the compass.



QUESTIONS TO ASK INTERVIEWEE BASED ON OTHER DATA SOURCES (VEHICLE INSPECTION, MEDICAL RECORDS, ETC.)

These reports are authorized by P.L. 89-563, Title 1, Section 106, 108, and 112. While you are not required to respond, your cooperation is needed to make the results of this data collection effort comprehensive, accurate, and timely.

A. CRASH DATA INFORMATION

IF POSSIBLE, OBTAIN THIS INFORMATION FROM THE DRIVER

A1. Avoidance actions (Mark all that apply)	<input type="checkbox"/> None	<input type="checkbox"/> Braking	<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)		

Use this space for any additional notes about the pre-crash and impact.

B. ROLLOVER INFORMATION

B1. 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. DRIVER ACTIONS

C1. 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:

D. ADDITIONAL VEHICLE INFORMATION

D1. Cargo in the vehicle (Describe any objects in the vehicle or trunk)	<input type="checkbox"/> No
	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes (describe)
Approximate weight of cargo: _____ pounds	

D2. Location of vehicle	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.
	<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 D3 – D5 for 2010 and newer vehicles only

D3. 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

D. ADDITIONAL VEHICLE INFORMATION (continued)

D4. 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)
D5. 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)

E. OCCUPANT DATA QUESTIONS

E1. 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																																				
E2. Seating position (Circle appropriate position of each occupant) If "Other" location, specify _____	Front <table border="1"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>4</td><td>5</td><td>6</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table> Other	1	2	3	4	5	6	7	8	9	Front <table border="1"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>4</td><td>5</td><td>6</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table> Other	1	2	3	4	5	6	7	8	9	Front <table border="1"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>4</td><td>5</td><td>6</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table> Other	1	2	3	4	5	6	7	8	9	Front <table border="1"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>4</td><td>5</td><td>6</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table> Other	1	2	3	4	5	6	7	8	9
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7	8	9																																						
1	2	3																																						
4	5	6																																						
7	8	9																																						
E3. Sex 1. Male 2. Female, not pregnant 3. Female, Pregnant, # of months 4. Female, unknown if pregnant	<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																																				
<i>If pregnant, indicate any crash related fetal complications on the mannequin page</i>																																								
E4. Height, Weight, Age 1. Height (Feet and inches) 2. Weight (Pounds) 3. Age (Years)	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____																																				

F. RESTRAINT INFORMATION

	DRIVER	OCCUPANT 2	OCCUPANT 3	OCCUPANT 4
F1. Was this occupant in a child safety seat? (If yes, complete separate Interview Form – Child Restraints)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
F2. 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
F3. 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

G. EJECTION, ENTRAPMENT, MOBILITY INFORMATION

	DRIVER	OCCUPANT 2	OCCUPANT 3	OCCUPANT 4
G1. Any part of body thrown outside the vehicle during the crash?				
1. No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
2. Unknown	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
3. Yes (describe parts of body ejected and what area of vehicle was involved)	<input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 3 (describe)
G2. Was occupant physically pinned in the vehicle?				
1. No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
2. Unknown	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
3. Yes (describe entrapment)	<input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 3 (describe)
G3. Was occupant trapped (but not pinned) in the vehicle?				
1. No	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
2. Unknown	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
3. Yes (describe entrapment)	<input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 3 (describe)	<input type="checkbox"/> 3 (describe)
G4. How did occupant exit the vehicle?				
1. Fatal before removed	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
2. Removed while unconscious or not oriented to time or place	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
3. Removed due to perceived serious injuries	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
4. Exited with some assistance	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
5. Exited under own power	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
6. Fully ejected	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
7. Removed for other reasons (specify)	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7
8. Unknown	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8

Further describe any ejection, entrapment or mobility information here.

H. AIR BAG INFORMATION

H1. 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 I) Unknown (SKIP TO SECTION I)

H2. Is this vehicle equipped with an air bag shut off switch?
 No Unknown Yes – Auto Position Yes – Off Position Yes – Unknown Position

H3. 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)

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

I. INJURY INFORMATION				
	DRIVER	OCCUPANT 2	OCCUPANT 3	OCCUPANT 4
I1. 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
I2. 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
I3. 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
I4. IF HOSPITAL MARKED IN I3, 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

J. INDIVIDUAL INJURY DESCRIPTION

J1. Identify which occupant is being reported on here:

PSU Number _____ Case Number _____ Vehicle Number _____ Occupant Number _____

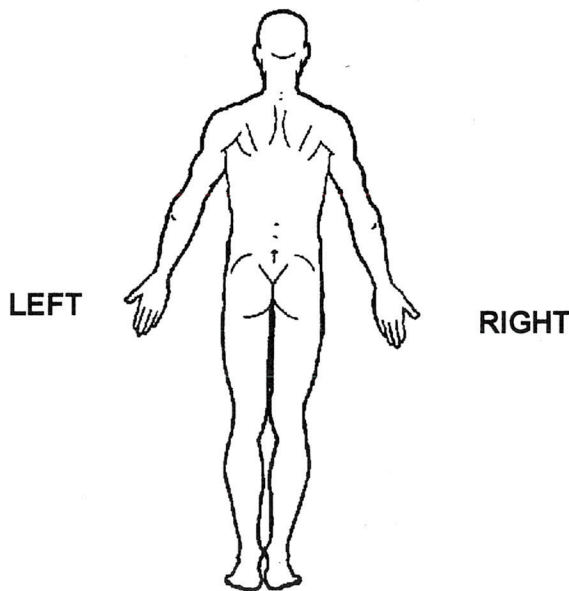
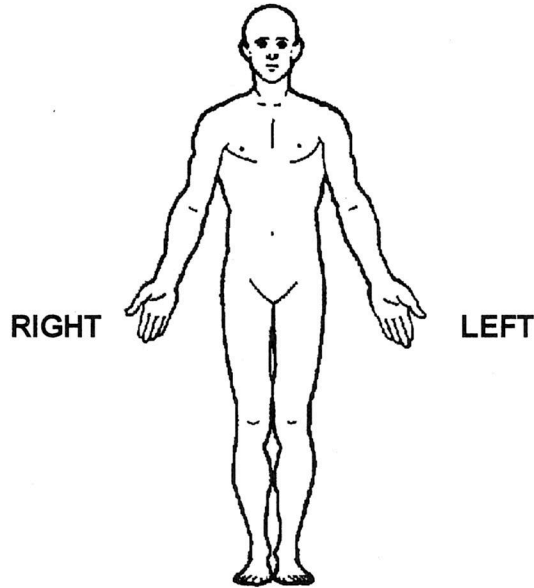
J2. Did occupant have any of the following injuries?

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

Annotate Injury, Location and Source

FRONT

No Injuries



BACK

J. INDIVIDUAL INJURY DESCRIPTION

J3. Identify which occupant is being reported on here:

PSU Number _____ Case Number _____ Vehicle Number _____ Occupant Number _____

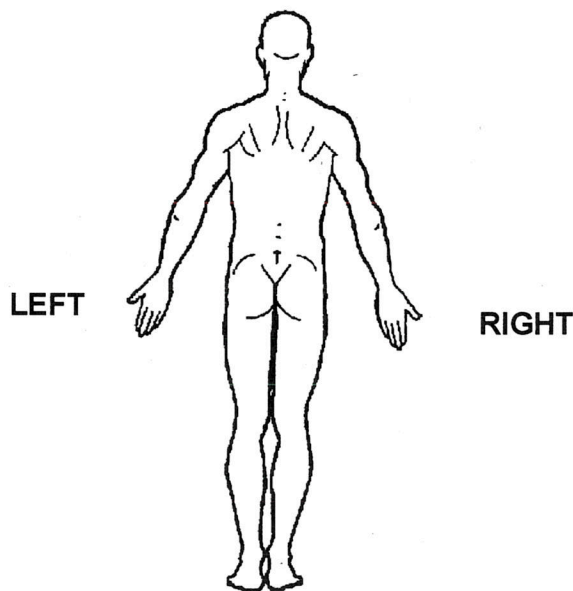
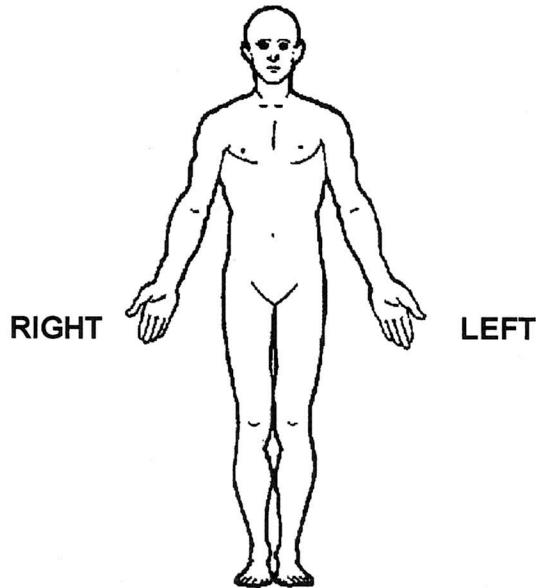
J4. Did occupant have any of the following injuries?

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

Annotate Injury, Location and Source

No Injuries

FRONT



BACK

J. INDIVIDUAL INJURY DESCRIPTION

J5. Identify which occupant is being reported on here:

PSU Number ____ Case Number ____ Vehicle Number ____ Occupant Number ____

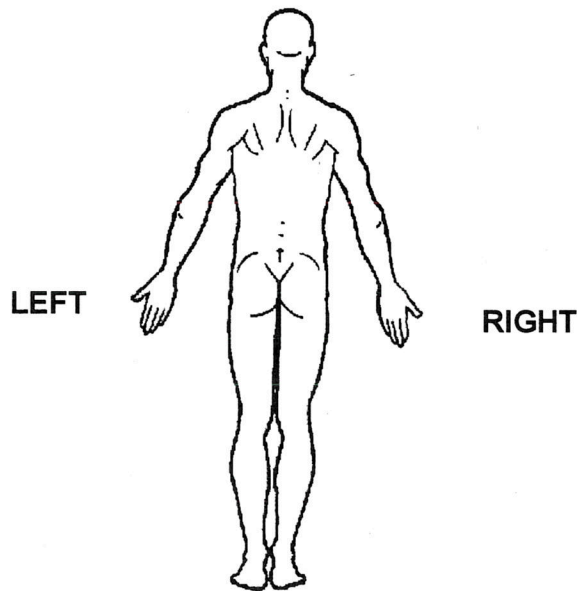
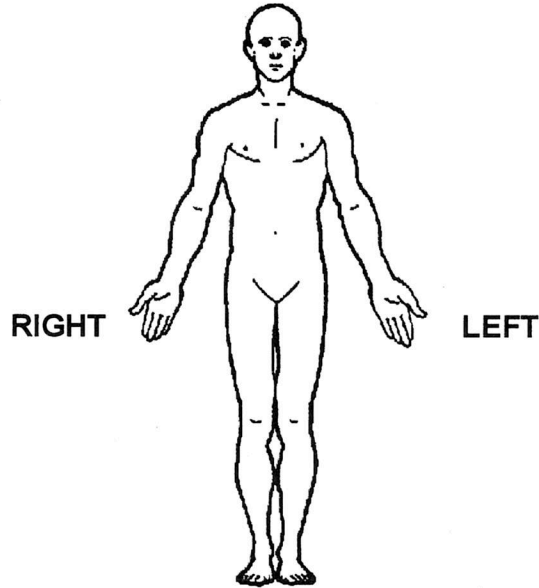
J6. Did occupant have any of the following injuries?

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

Annotate Injury, Location and Source

No Injuries

FRONT



BACK

J. INDIVIDUAL INJURY DESCRIPTION

J7. Identify which occupant is being reported on here:

PSU Number _____ Case Number _____ Vehicle Number _____ Occupant Number _____

J8. Did occupant have any of the following injuries?

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

Annotate Injury, Location and Source

No Injuries

