

A. OCCUPANT DATA QUESTIONS

A1. 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	OCCUPANT 5	OCCUPANT 6	OCCUPANT 7	OCCUPANT 8																																																
A2. 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> <tr><td colspan="3">Other</td></tr> </table>	1	2	3	4	5	6	7	8	9	Other			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> <tr><td colspan="3">Other</td></tr> </table>	1	2	3	4	5	6	7	8	9	Other			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> <tr><td colspan="3">Other</td></tr> </table>	1	2	3	4	5	6	7	8	9	Other			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> <tr><td colspan="3">Other</td></tr> </table>	1	2	3	4	5	6	7	8	9	Other		
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Other																																																				
A3. 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>																																																				
A4. 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. _____																																																
A5. 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"/> 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																																																
A6. Ethnicity 1. Not of Hispanic origin 2. Of Hispanic origin 3. Unknown if of Hispanic origin	<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																																																
A7. Occupant wearing glasses or have any objects in mouth/hand? (Mark if Yes and describe)	<input type="checkbox"/> Yes (Describe) <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes (Describe) <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes (Describe) <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes (Describe) <input type="checkbox"/> No <input type="checkbox"/> Unk																																																

B. RESTRAINT INFORMATION				
	OCCUPANT 5	OCCUPANT 6	OCCUPANT 7	OCCUPANT 8
B1. Was this occupant in a child safety seat? <i>(If yes, complete separate Interview Form – Child Restraints)</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	<input type="checkbox"/> Yes <input type="checkbox"/> No
B2. 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
B3. 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
B4. Was there an upper anchorage adjustment for the 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"/> 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
B5. Belt position for lap belt: 1. Snug and low across hips 2. Across abdomen 3. Low across hips with extra “slack” 4. Across abdomen with extra “slack” 5. Other position (specify) 6. Unknown position	<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"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<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"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
B6. Belt position for shoulder belt: 1. Snug across collarbone and over shoulder 2. Resting on neck 3. On edge of shoulder 4. Under arm 5. Behind occupants back or seat 6. Other position (specify) 7. Unknown belt position	<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
Was there any “slack room” in the belt?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
B7 Seating posture 1. Upright- back against seatback 2. Leaning forward 3. Leaning to the left 4. Leaning to the right 5. Lying across seat 6. Other (describe) 7. 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"/> 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

C. EJECTION, ENTRAPMENT, MOBILITY INFORMATION

	OCCUPANT 5	OCCUPANT 6	OCCUPANT 7	OCCUPANT 8
C1. 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)
C2. 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)
C3. 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)
C4. 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.

D. INJURY INFORMATION				
	OCCUPANT 5	OCCUPANT 6	OCCUPANT 7	OCCUPANT 8
D1. 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
D2. 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
D3. 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
D4. IF HOSPITAL MARKED IN D3, 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
D5. 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

E. INDIVIDUAL INJURY DESCRIPTION

E1. Identify which occupant is being reported on here:

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

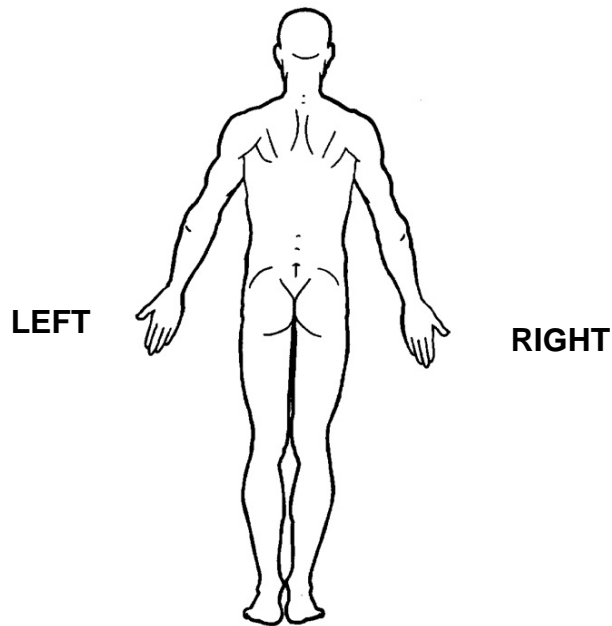
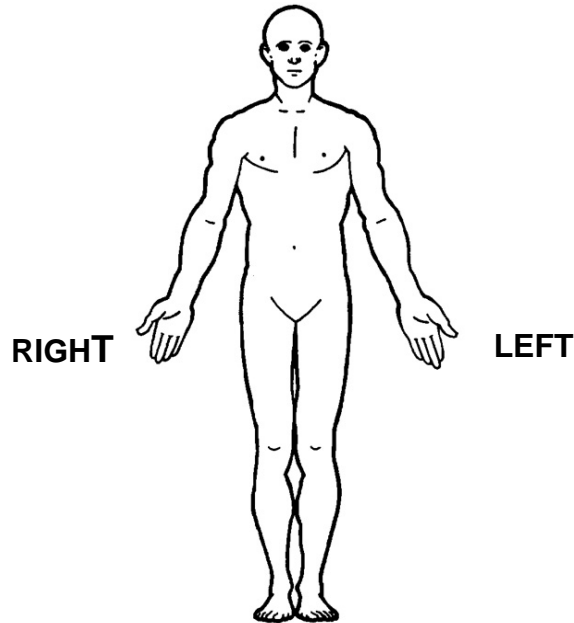
E2. Did occupant have any of the following injuries?

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

Annotate Injury, Location and Source

No Injuries

FRONT



BACK

E. INDIVIDUAL INJURY DESCRIPTION

E3. Identify which occupant is being reported on here:

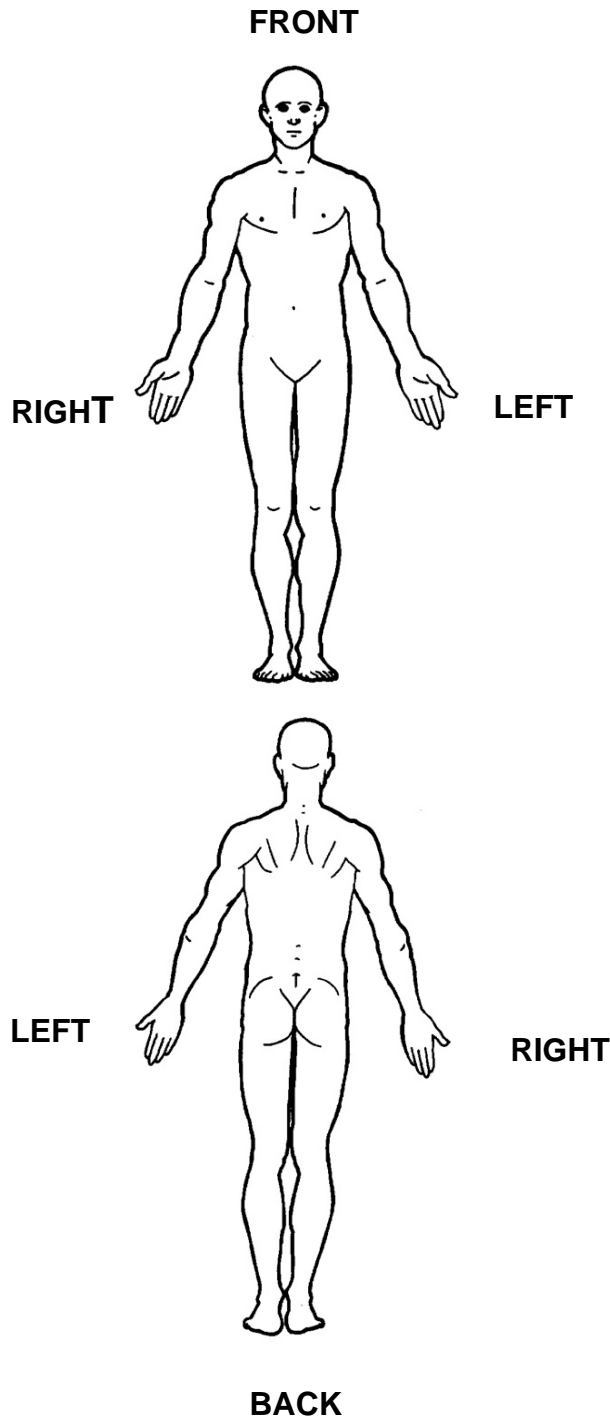
PSU Number ____ Case Number ____ Vehicle Number ____ Occupant Number ____

E4. 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



E. INDIVIDUAL INJURY DESCRIPTION

E5. Identify which occupant is being reported on here:

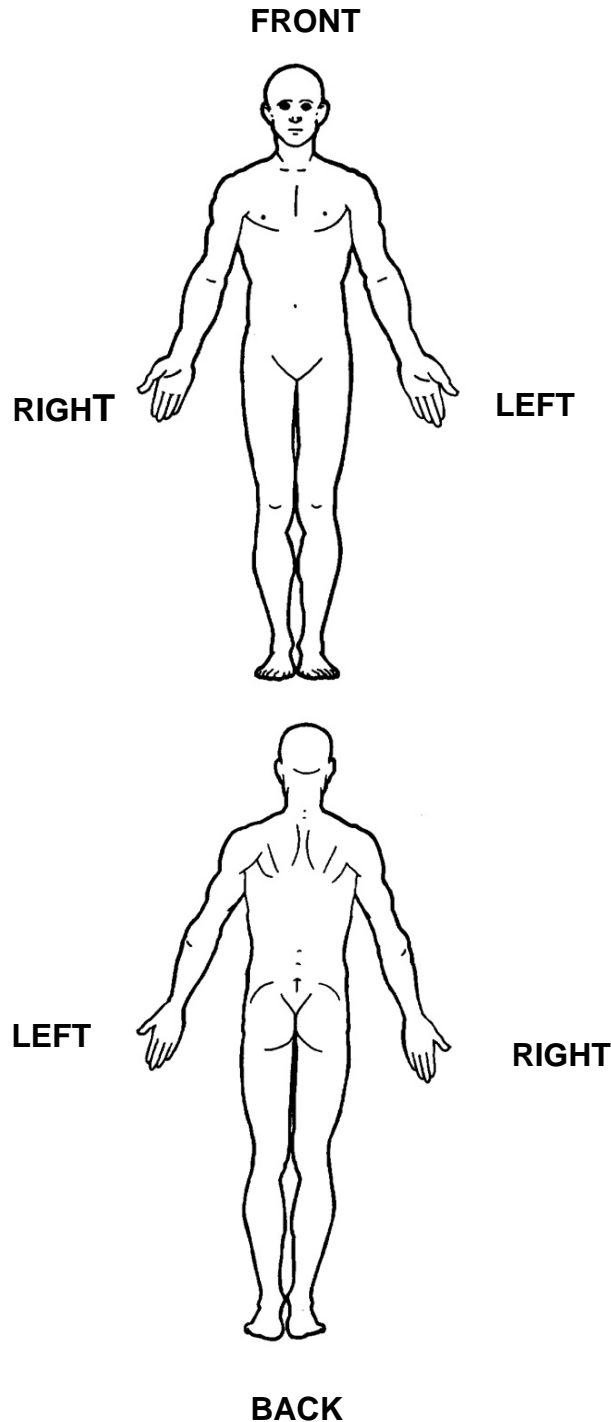
PSU Number ____ Case Number ____ Vehicle Number ____ Occupant Number ____

E6. 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



E. INDIVIDUAL INJURY DESCRIPTION

E7. Identify which occupant is being reported on here:

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

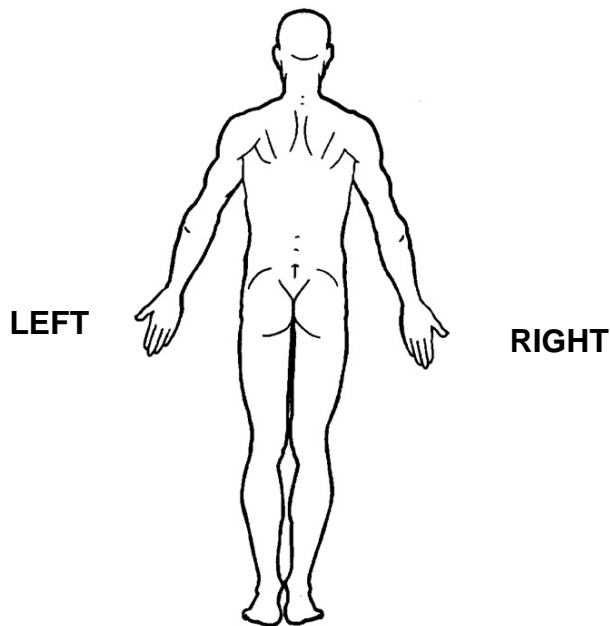
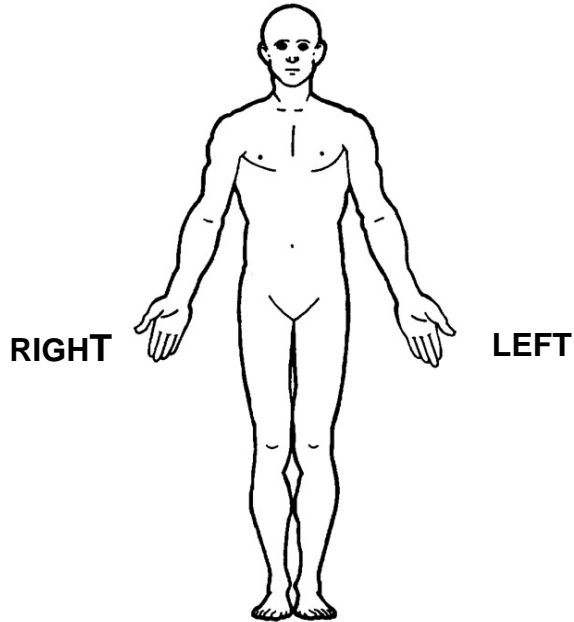
E8. Did occupant have any of the following injuries?

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

Annotate Injury, Location and Source

No Injuries

FRONT



BACK

