



## Interview Form Cover Sheet

PSU Number    ___ ___  Case Number    ___ ___ ___ ___  Vehicle Number    ___ ___	Interviewee(s) Role or Name(s): _____ _____  Phone Number: (    ___ ) _____
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Occupant #	Name	Date of Birth	Medical Facility <i>(If multiple treatment locations – list all, including treatment later)</i>	Discharge Date(s)
1				
2				
3				
4				
5				
6				

**Date, Time and Place to have medical release signed:**

\_\_\_\_\_

**Other identifying information:**

\_\_\_\_\_

A federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with, a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2127-0706. Public reporting for this collection of information is estimated to be approximately 20 minutes for interviewee, 3-15 minutes for police jurisdiction, 10 minutes for medical record, and 5 minutes for tow yard employees. All responses to this collection of information are voluntary. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, National Highway Traffic Safety Administration, 1200 New Jersey Ave, S.E., Room W45-205, Washington, DC, 20590.



**A. CRASH DATA INFORMATION**

IF POSSIBLE, OBTAIN THIS INFORMATION FROM THE DRIVER

<b>A1. Avoidance actions</b> (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**

<b>B1. Plane in contact with ground at final rest</b>	<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**

<b>C1. Prior to the crash, was the driver doing any of the following?</b> (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**

<b>D1. Cargo in the vehicle</b> (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

<b>D2. Location of vehicle</b>	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**

<b>D3. Is the vehicle equipped with any of the following features?</b> (Mark all that apply)	<input type="checkbox"/> Lane Keeping Support	<input type="checkbox"/> Daytime Running Light
	<input type="checkbox"/> Lane Departure Warning	<input type="checkbox"/> Rearview Video System
	<input type="checkbox"/> Crash Imminent Braking	<input type="checkbox"/> Dynamic Brake Support
	<input type="checkbox"/> Forward Collision Warning	<input type="checkbox"/> Pedestrian Automatic Emergency Braking
	<input type="checkbox"/> Blind Spot Detection	<input type="checkbox"/> Advanced Lighting
	<input type="checkbox"/> Automatic Crash Notification	<input type="checkbox"/> Adaptive Cruise Control

**D. ADDITIONAL VEHICLE INFORMATION (continued)**

<b>D4. Were any of the avoidance features (listed in D3) disabled at the time of the crash?</b>	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (describe)
<b>D5. Did occupants see, hear, or feel anything to indicate activation of the above features?</b>	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (describe)

**E. OCCUPANT DATA QUESTIONS**

<b>E1. Including the driver, how many people were in the vehicle at the time of the crash? _____</b>																																																				
<b>Please respond to each question for the driver and up to three additional occupants</b>	<b>DRIVER</b>	<b>OCCUPANT 2</b>	<b>OCCUPANT 3</b>	<b>OCCUPANT 4</b>																																																
<b>E2. Seating position</b> <i>(Circle appropriate position of each occupant)</i> If "Other" location, specify _____	Front <table border="1" style="margin: auto; border-collapse: collapse;"> <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" style="text-align:center;">Other</td></tr> </table>	1	2	3	4	5	6	7	8	9	Other			Front <table border="1" style="margin: auto; border-collapse: collapse;"> <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" style="text-align:center;">Other</td></tr> </table>	1	2	3	4	5	6	7	8	9	Other			Front <table border="1" style="margin: auto; border-collapse: collapse;"> <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" style="text-align:center;">Other</td></tr> </table>	1	2	3	4	5	6	7	8	9	Other			Front <table border="1" style="margin: auto; border-collapse: collapse;"> <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" style="text-align:center;">Other</td></tr> </table>	1	2	3	4	5	6	7	8	9	Other		
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<b>E3. Sex</b> 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>																																																				
<b>E4. Height, Weight, Age</b> 1. Height <i>(Feet and inches)</i> 2. Weight <i>(Pounds)</i> 3. Age <i>(Years)</i>	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____																																																
<b>E5. Race /Ethnicity</b> 1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 6. Hispanic or Latino 7. Middle Eastern or North African 8. Other (specify) 9. 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"/> Yes (Describe) <input type="checkbox"/> 9	<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"/> Yes (Describe) <input type="checkbox"/> 9	<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"/> Yes (Describe) <input type="checkbox"/> 9	<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"/> Yes (Describe) <input type="checkbox"/> 9																																																
<b>E7. Occupant wearing glasses or have any objects in mouth/hand?</b> (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																																																

F. RESTRAINT INFORMATION				
	DRIVER	OCCUPANT 2	OCCUPANT 3	OCCUPANT 4
<b>F1. Was this occupant in a child safety seat?</b> (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
<b>F2. Type of seat belt available</b> 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
<b>F3. Occupant wearing any seatbelt?</b> 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
<b>F4. Was there an upper anchorage adjustment for the seat belt?</b> (If yes, indicate position) 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
<b>F5. Belt position for lap belt:</b> 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
<b>F6. Belt position for shoulder belt:</b> 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
<b>Was there any "slack room" in the belt?</b>	<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

**F7. Seating posture**

1. Normal Posture	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
2. Kneeling or standing on seat	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
3. Lying on a or across seat	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
4. Kneeling, <u>standing</u> or sitting in front of seat	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
5. Sitting sideways or turned	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
6. Sitting on a console	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
7. Lying back in a reclined seat position	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7
8. Bracing with feet or hands on a surface of the vehicle	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8
9. In the lap of another occupant	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9
10. Sharing a seat-sitting side by side	<input type="checkbox"/> 10	<input type="checkbox"/> 10	<input type="checkbox"/> 10	<input type="checkbox"/> 10
11. In a child seat	<input type="checkbox"/> 11	<input type="checkbox"/> 11	<input type="checkbox"/> 11	<input type="checkbox"/> 11
12. Other posture (specify):	<input type="checkbox"/> 12	<input type="checkbox"/> 12	<input type="checkbox"/> 12	<input type="checkbox"/> 12
13. Unknown	<input type="checkbox"/> 13	<input type="checkbox"/> 13	<input type="checkbox"/> 13	<input type="checkbox"/> 13

**G. EJECTION, ENTRAPMENT, MOBILITY INFORMATION**

	DRIVER	OCCUPANT 2	OCCUPANT 3	OCCUPANT 4
<b>G1. Any part of body thrown outside the vehicle during the crash?</b>				
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)
<b>G2. Was occupant physically pinned in the vehicle?</b>				
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)
<b>G3. Was occupant trapped (but not pinned) in the vehicle?</b>				
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)
<b>G4. How did occupant exit the vehicle?</b>				
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?                 | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes (# of previous crashes_____) |
| If yes, did the airbag(s) deploy?         | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes (describe below)             |
| If yes, were airbag(s) reinstalled?       | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes (describe below)             |
| Had prior maintenance/service on air bag? | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes (describe below)             |

**H4. Type of air bag:**

- Original manufacturer installed
- Replacement air bag
- Retrofitted air bag
- Unknown

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
<b>I1. Was occupant injured?</b> 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
<b>I2. Was occupant transported directly from crash scene for treatment?</b> 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
<b>I3. Did occupant receive any medical treatment, including treatment later?</b>	If 2, 3, 4, or 5 is selected, record medical facility information on the cover page.			
1. No 2. EMS at scene 3. Hospital 4. Medical clinic 5. Doctor's office 6. Treated by self 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
<b>I4. IF HOSPITAL MARKED IN I3, Which describes occupant's treatment level?</b> 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
<b>I5. Did occupant miss any days of work or school as a result of the crash? (Includes full-time college student)</b> 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

**J. INDIVIDUAL INJURY DESCRIPTION**

**J1. Identify which occupant is being reported on here:**

PSU Number \_\_\_\_\_ Case Number \_\_\_\_\_ Vehicle Number \_\_\_\_\_ Occupant Number \_\_\_\_\_

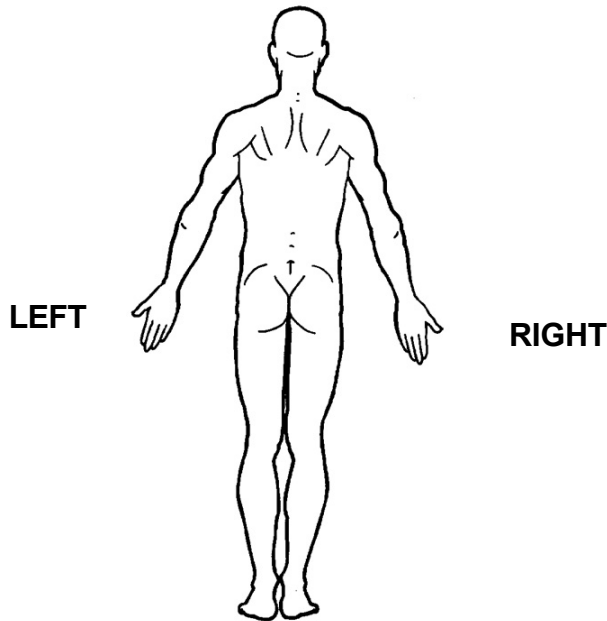
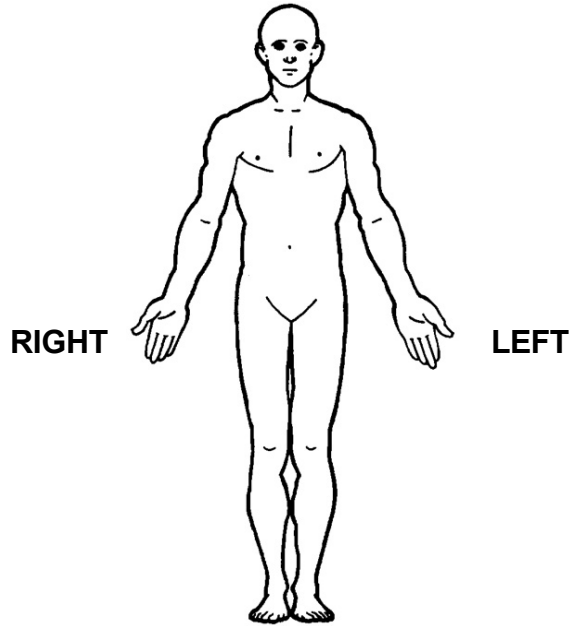
**J2. Did occupant have any of the following injuries?**

- 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 \_\_\_\_\_

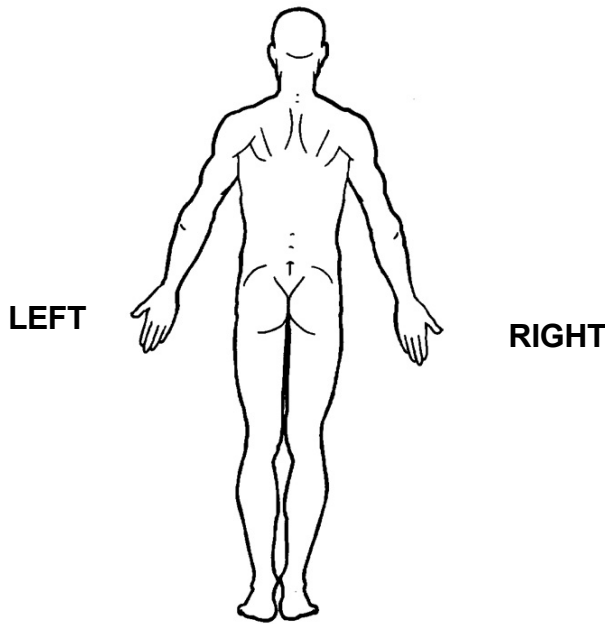
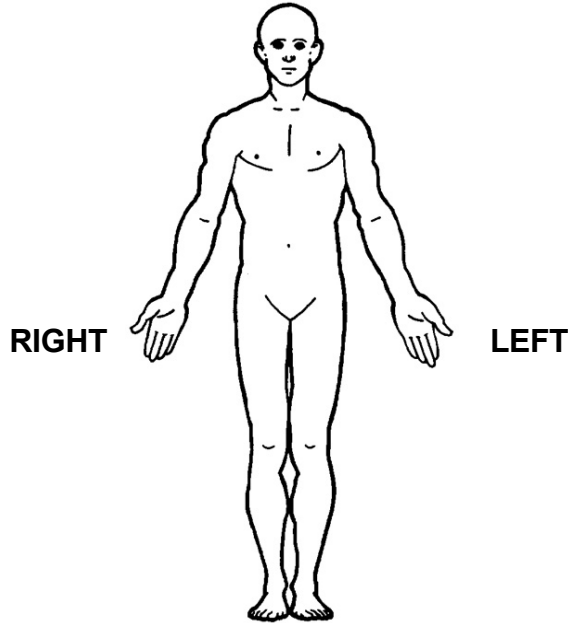
**J4. Did occupant have any of the following injuries?**

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

**Annotate Injury, Location and Source**

**FRONT**

No Injuries



**BACK**

**J. INDIVIDUAL INJURY DESCRIPTION**

**J5. Identify which occupant is being reported on here:**

PSU Number \_\_\_\_\_ Case Number \_\_\_\_\_ Vehicle Number \_\_\_\_\_ Occupant Number \_\_\_\_\_

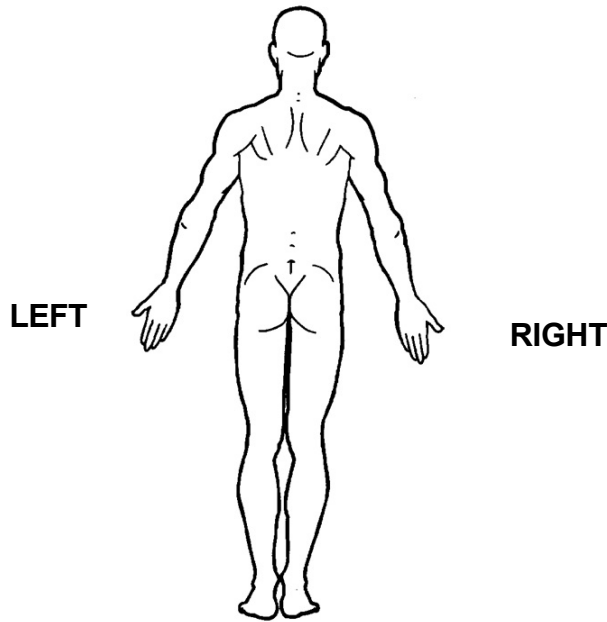
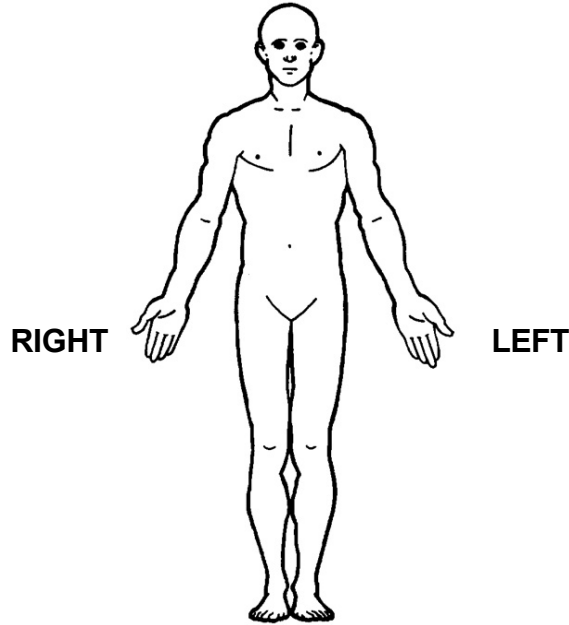
**J6. Did occupant have any of the following injuries?**

- 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 \_\_\_\_\_

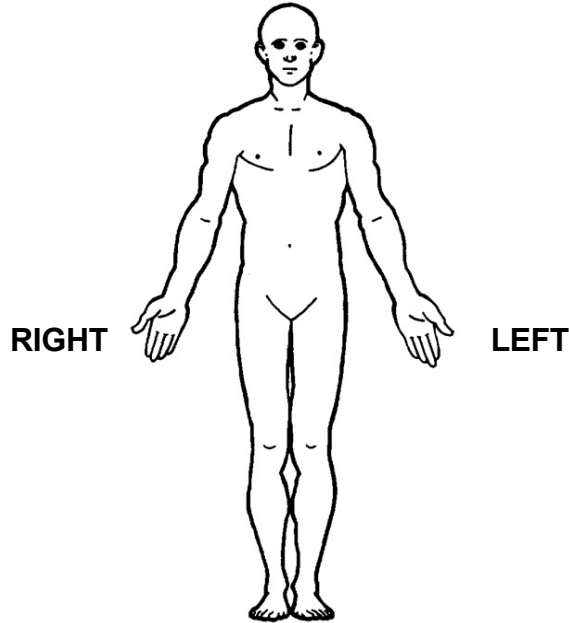
**J8. Did occupant have any of the following injuries?**

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

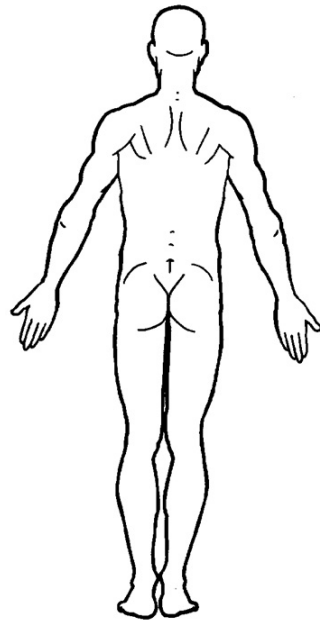
**Annotate Injury, Location and Source**

No Injuries

**FRONT**



**LEFT**



**RIGHT**

**BACK**