



MOTORCYCLE CRASH, OTHER INVOLVED DRIVER INTERVIEW FORM

PSU Number: _____		Case Number: _____		
Vehicle Number: _____		Occupant Number: _____		
Occupant #	Name and Phone Number	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:				
<input type="checkbox"/> Uninjured <input type="checkbox"/> Fatal Injury (Date and time of death): <input type="checkbox"/> Fetal Mortality (Date and time of death):				

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MOTORCYCLE CRASH, OTHER INVOLVED DRIVER INTERVIEW FORM

PSU Number: _____

Case Number: _____

DRIVER OR OCCUPANT DESCRIPTION AND DIAGRAM OF CRASH EVENTS

Interviewee Role:

Use this space to sketch the interviewee's description of the crash

QUESTIONS TO ASK INTERVIEWEE BASED UPON OTHER DATA SOURCES (VEHICLE INSPECTION, SCENE, ETC.)

Trip Details and Behavior

1. What was the main purpose of your driving trip on the day of the crash?

- | | |
|---|--|
| <input type="checkbox"/> Commuting to/from work | <input type="checkbox"/> Drop off/pick someone up |
| <input type="checkbox"/> Commuting to/from school | <input type="checkbox"/> Visiting a friend or relative |
| <input type="checkbox"/> Recreation | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Personal errand (to/from store, post office, etc.) | <input type="checkbox"/> Other (Specify) _____ |

2. Was this the vehicle you normally drove?

-
- Yes
-
- Unknown
-
- No, explain:

3. How long had you driven the vehicle before the crash?

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Less than one month | <input type="checkbox"/> 2+ years |
| <input type="checkbox"/> 1 – 6 months | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> 6 months to 2-years | |

Pre-Crash Information

4. Before the crash, which lane were you traveling in?
5. Before the crash, what were you intending to do?

- | | |
|--|--|
| <input type="checkbox"/> Continue straight | <input type="checkbox"/> Change lanes to the left |
| <input type="checkbox"/> Slow | <input type="checkbox"/> Change lanes to the right |
| <input type="checkbox"/> Turn left | <input type="checkbox"/> Back-up |
| <input type="checkbox"/> Turn right | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Accelerate | <input type="checkbox"/> Other (Specify) _____ |

6. Did you see the motorcycle before impact?

-
- Yes
-
- No
-
- Unknown

**7. Can you estimate how far away the motorcycle was when you first noticed it?
(Distance, time, or other description)**
8. Can you estimate your travel speed before the crash?

-
- Unknown

9. Can you estimate the speed of the motorcycle before the crash?

-
- Unknown

10. If so, what direction was the motorcycle coming from?

- | | |
|--|---|
| <input type="checkbox"/> Same direction behind | <input type="checkbox"/> Perpendicular to the right |
| <input type="checkbox"/> Same direction ahead | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Opposite direction | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Perpendicular to the left | |

11. Did you take any avoidance actions prior to the impact with the motorcycle?

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Steering left |
| <input type="checkbox"/> Braking with lock-up | <input type="checkbox"/> Steering right |
| <input type="checkbox"/> Braking without lock-up | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Releasing brakes | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Accelerating | <input type="checkbox"/> Other (Specify) _____ |

Pre-Crash Information (continued)**12. Prior to the crash, was the driver doing any of the following?**

(Select all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Dealing with child/passenger inside the car | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Looking for something inside the car | <input type="checkbox"/> Sleeping or falling asleep |
| <input type="checkbox"/> Distracted by another occupant | <input type="checkbox"/> Looking for something outside of the vehicle
(street sign, building, etc.) |
| <input type="checkbox"/> Adjusting an internal control, such as radio,
climate control, opening glove compartment | <input type="checkbox"/> Having personal thought/daydreaming/thinking |
| <input type="checkbox"/> Using a handheld device such as a cell phone
or electronic organizer | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Eating or drinking | <input type="checkbox"/> Not Applicable |
| | <input type="checkbox"/> Other (Specify)_____ |

13. Describe how your vehicle moved to its stopped location immediately following the crash.**14. Describe how the motorcycle moved to its stopped location immediately following the crash.****Vehicle Information (Model Year 2010 and Newer)****15. Location of vehicle***(If vehicle has not yet been inspected, mark appropriate box to the right and record current location and contact person on cover sheet)*

- | |
|--|
| <input type="checkbox"/> Vehicle Inspected |
| <input type="checkbox"/> Vehicle location recorded on cover sheet |
| <input type="checkbox"/> Insurance information recorded on cover sheet |

16. Was the vehicle equipped with any of the following features?

- | | |
|---|---|
| <input type="checkbox"/> Lane Keeping Support | <input type="checkbox"/> Dynamic Brake Support |
| <input type="checkbox"/> Lane Departure Warning | <input type="checkbox"/> Blind Spot Detection |
| <input type="checkbox"/> Crash Imminent Braking | <input type="checkbox"/> Daytime Running Lights |
| <input type="checkbox"/> Forward Collision Warning | <input type="checkbox"/> Advanced Lighting |
| <input type="checkbox"/> Adaptive Cruise Control | <input type="checkbox"/> Rearview Video System |
| <input type="checkbox"/> Pedestrian Automatic Emergency Braking | <input type="checkbox"/> Automatic Crash Notification |

17. Were any of the above avoidance features disabled at the time of the crash?

-
- Yes
-
- No
-
- Unknown

18. Did occupants see, hear, or feel anything to indicate activation of the above avoidance features?

-
- Yes
-
- No
-
- Unknown

19. Were your headlights on? Do they automatically activate, or did you turn them on?

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Yes, automatic | <input type="checkbox"/> No, manual |
| <input type="checkbox"/> Yes, manual | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> No, automatic | |

20. Were your headlights on high beam or low beam?

- | | |
|------------------------------------|----------------------------------|
| <input type="checkbox"/> High beam | <input type="checkbox"/> Not on |
| <input type="checkbox"/> Low beam | <input type="checkbox"/> Unknown |

21. When the crash occurred during precipitation: Were the windshield wipers activated? Do they activate automatically, or did you turn them on?

- | | |
|---|---|
| <input type="checkbox"/> Yes, automatic | <input type="checkbox"/> No, automatic |
| <input type="checkbox"/> Yes, manual | <input type="checkbox"/> No, manual |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Not applicable |

Occupant Information		
	Driver	Occupant #1
29. Seating position		
30. Sex		
31. If pregnant, # of months		
32. Height		
33. Weight		
34. Age		
35. Race/Ethnicity		
37. Occupant wearing glasses or have any objects in hand/mouth		
38. Was this occupant in a child safety seat? <i>(If yes, complete separate interview form – Child Restraints)</i>		
39. Type of seatbelt available		
40. Occupant wearing any seatbelt?		
41. Was there an upper anchorage adjustment for the seatbelt? <i>(If yes, indicate position)</i>		
42. Belt position for lap belt		
43. Belt position for shoulder belt		
44. Seating Posture		
45. Any part of the body thrown outside of the vehicle during the crash? <i>(If yes, describe parts of the body ejected and what area of the vehicle was involved)</i>		
46. Was the occupant physically pinned in the vehicle? <i>(If yes, describe entrapment)</i>		
47. Was the occupant trapped (but not pinned) in the vehicle? <i>(If yes, describe entrapment)</i>		
48. How did the occupant exit the vehicle?		

Occupant Information		
	Occupant #3	Occupant #4
49. Seating position		
50. Sex		
51. If pregnant, # of months		
52. Height		
53. Weight		
54. Age		
55. Race/Ethnicity		
57. Occupant wearing glasses or have any objects in hand/mouth		
58. Was this occupant in a child safety seat? <i>(If yes, complete separate interview form – Child Restraints)</i>		
59. Type of seatbelt available		
60. Occupant wearing any seatbelt?		
61. Was there an upper anchorage adjustment for the seatbelt? <i>(If yes, indicate position)</i>		
62. Belt position for lap belt		
63. Belt position for shoulder belt		
64. Seating Posture		
65. Any part of the body thrown outside of the vehicle during the crash? <i>(If yes, describe parts of the body ejected and what area of the vehicle was involved)</i>		
66. Was the occupant physically pinned in the vehicle? <i>(If yes, describe entrapment)</i>		
67. Was the occupant trapped (but not pinned) in the vehicle? <i>(If yes, describe entrapment)</i>		
68. How did the occupant exit the vehicle?		

Occupant Information (continued)

69. Further describe and ejection, entrapment, or mobility information here:

Injury Information

	Driver	Occupant #1
70. Was occupant injured?		
71. Was occupant transported directly from crash scene for treatment?		
72. Did occupant receive any medical treatment?		
73. IF HOSPITAL MARKED, Which describes occupant's treatment level?		
74. Did occupant miss any days of work or school as a result of the crash <i>(Includes full-time college student)</i>		
	Occupant #3	Occupant #4
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INDIVIDUAL INJURY DESCRIPTION

Identify which occupant is being reported on here:

PSU Number: _____

Case Number: _____

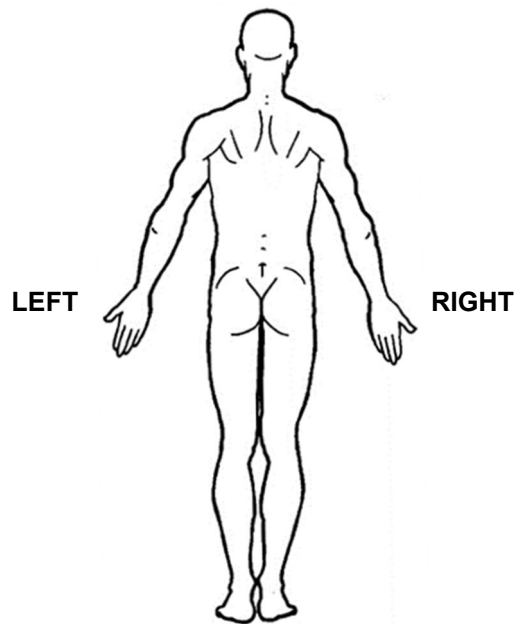
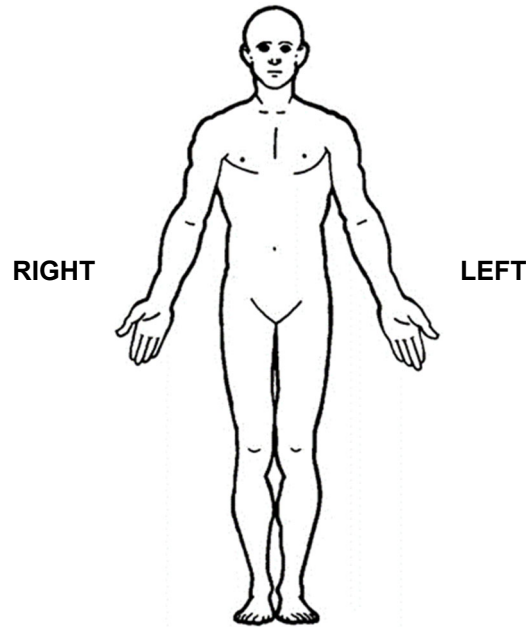
Occupant Number: _____

Did occupant have any of the following injuries:

- Cuts Abrasions Bruises Fractures Head/Skull/Brain Internal Sprains/Strains Other

Annotate injury type, details including location, and source

FRONT



BACK

INDIVIDUAL INJURY DESCRIPTION

Identify which occupant is being reported on here:

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Case Number: _____

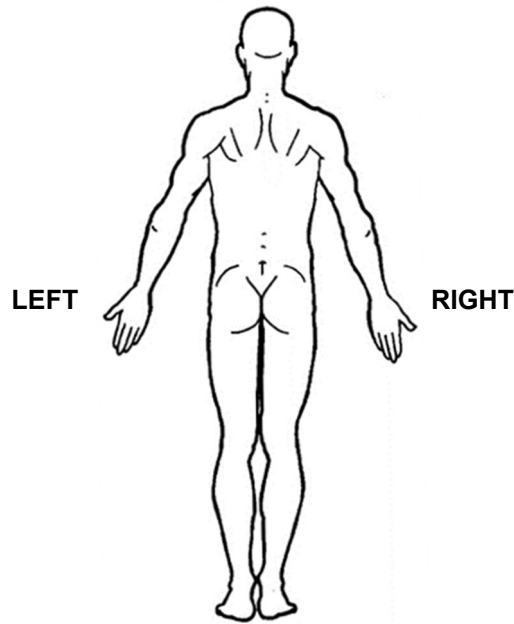
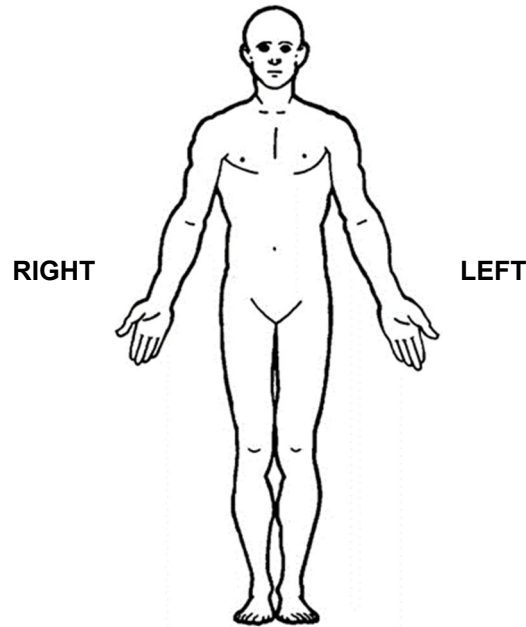
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FRONT



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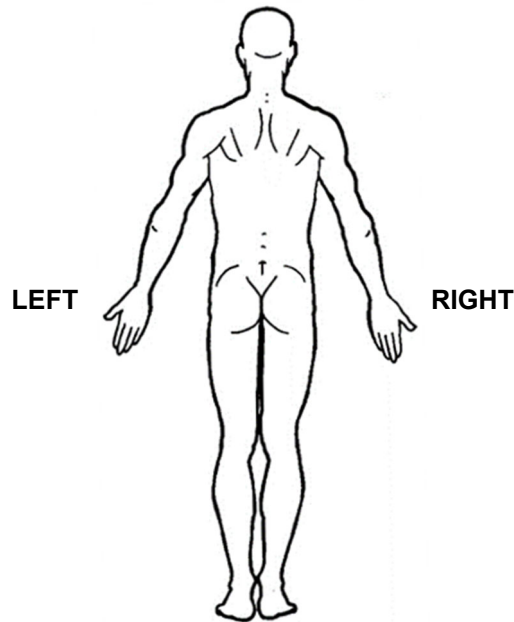
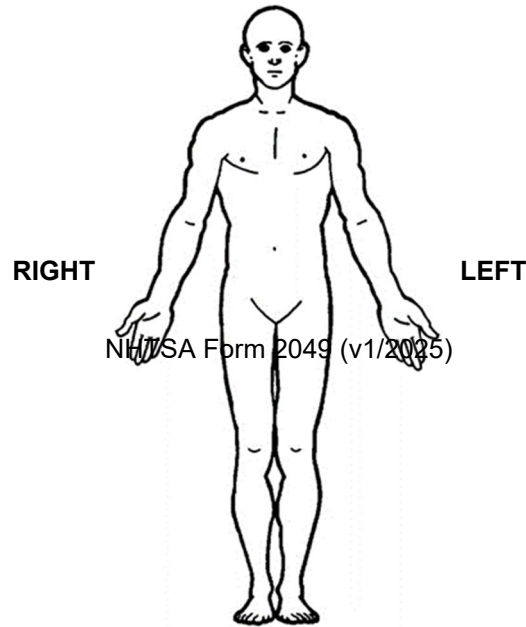
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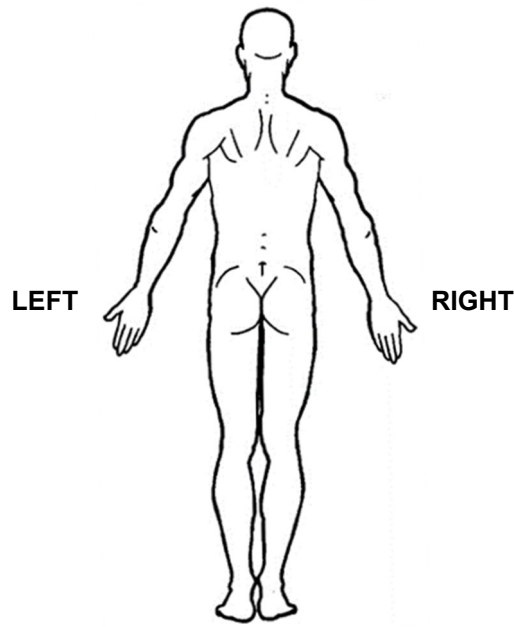
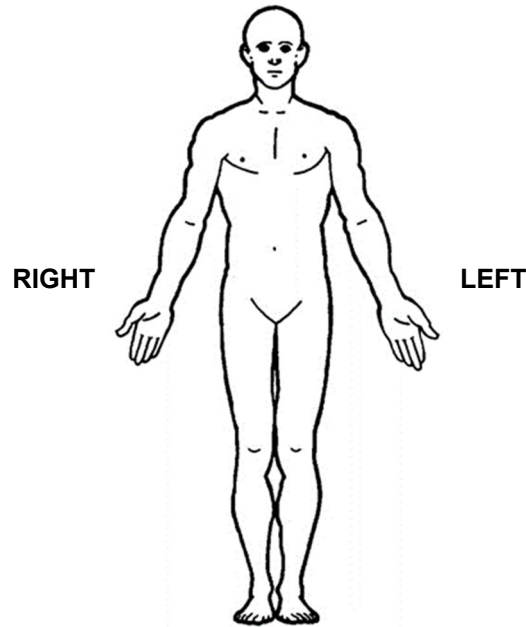
PSU Number: _____ Case Number: _____ Occupant Number: _____

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