

HOW TO READ YOUR INDIANA ACCIDENT REPORT

The top of this page includes information about exactly when and where your accident happened in Indiana. The number of vehicles involved as well as the number of injuries and fatalities in the accident can be found here, as well. Verify all this information. Insurance companies often point out any discrepancies when denying accident claims.

The middle of this page contains information about the primary cause of your accident. Some of the options the investigating police officer can check include "unsafe speed," "driver asleep or fatigued," "improper passing" and "alcoholic beverages." The same part of the page on the right side contains information about whether your accident was a hit-and-run, weather conditions and whether your crash took place on a rural or city road.

PAGE ONE

INDIANA OFFICER'S STANDARD CRASH REPORT													
State Form: 23558 (Revised 2/03) Stock 302					Report <input type="radio"/> Original <input type="radio"/> Supplemental Page <input type="text"/> of <input type="text"/>								
Mail to: Indiana State Police, Crash Records Section 100 North Senate Avenue, Indianapolis, IN 46204					000012345								
Local ID													
Day of Week		Actual Local Time <input type="radio"/> AM <input type="radio"/> PM		County		Township		# Motor Vehicles		# Injured	# Dead	# Commercial Vehicles	# Deer
Occurred On		Nearest/Intersecting Road /Mile/Marker/Interchange				If not at an intersection, number of feet from		Direction		Road Type <input type="radio"/> Interstate <input type="radio"/> County Road <input type="radio"/> US Road <input type="radio"/> Local/City Road <input type="radio"/> State Road <input type="radio"/> Other			
Nearest City/Town		Inside Corporate Limits? <input type="radio"/> Yes <input type="radio"/> No		Property? <input type="radio"/> Private <input type="radio"/> DNR <input type="radio"/> Other		Crash Latitude		Crash Longitude					
Driver #2		Driver #3		Driver #4									
Fill in only one Primary Cause for the crash													
Fill in two ovals for Driver and Contributing Circumstances				Fill in one oval per vehicle for Vehicle and Environment Contributing Circumstances				Area Information: Fill in one oval per category					
Contributing Circumstance <input type="radio"/> Alcoholic Beverages <input type="radio"/> Illegal Drugs <input type="radio"/> Prescription Drugs <input type="radio"/> Driver Asleep or Fatigued <input type="radio"/> Driver Illness <input type="radio"/> Unsafe Speed <input type="radio"/> Failure to Yield Right of Way <input type="radio"/> Disregard Signal/Regulatory Sign <input type="radio"/> Left of Center <input type="radio"/> Improper Passing <input type="radio"/> Improper Turning <input type="radio"/> Improper Lane Usage <input type="radio"/> Following Too Closely <input type="radio"/> Unsafe Backing <input type="radio"/> Overcorrecting/Oversteering <input type="radio"/> Ran off Road <input type="radio"/> Wrong Way on One Way <input type="radio"/> Pedestrian's Action <input type="radio"/> Passenger Distraction <input type="radio"/> Violation of License Restriction <input type="radio"/> Jackknifing <input type="radio"/> Cell Phone Usage <input type="radio"/> Other Telematics in Use <input type="radio"/> Driver Distracted (Explain in Narrative) <input type="radio"/> Speed Too Fast for Weather Conditions <input type="radio"/> Other (Explain in Narrative) <input type="radio"/> None				Vehicle Contributing Circumstance Primary Cause Vehicle 1 Vehicle 2 Vehicle 3 Vehicle 4 <input type="radio"/> Engine Failure or Defective <input type="radio"/> Accelerator Failure or Defective <input type="radio"/> Brake Failure or Defective <input type="radio"/> Tire Failure or Defective <input type="radio"/> Headlight(s) Defective or Not On <input type="radio"/> Other Lights Defective <input type="radio"/> Steering Failure <input type="radio"/> Window/Windshield Defective <input type="radio"/> Oversize/Overweight Load <input type="radio"/> Insecure/Leaky Load <input type="radio"/> Tow Hitch Failure <input type="radio"/> Other (Explain in Narrative) <input type="radio"/> None				Hit and Run <input type="radio"/> Yes <input type="radio"/> No Light Condition <input type="radio"/> Daylight <input type="radio"/> Dawn/Dusk <input type="radio"/> Dark (Lighted) <input type="radio"/> Dark (Not Lighted) <input type="radio"/> Unknown Type of Median <input type="radio"/> Driveable <input type="radio"/> Curbed <input type="radio"/> Barrier Wall <input type="radio"/> None Locality <input type="radio"/> Rural <input type="radio"/> Urban Weather Conditions <input type="radio"/> Clear <input type="radio"/> Cloudy <input type="radio"/> Rain <input type="radio"/> Snow <input type="radio"/> Sleet/Hail <input type="radio"/> Freezing Rain <input type="radio"/> Fog/Smoke/Smog <input type="radio"/> Severe Cross Wind <input type="radio"/> Blowing Sand/Soil/Snow Type of Roadway Junction <input type="radio"/> No Junction Involved <input type="radio"/> Four-Way Intersection <input type="radio"/> T-Intersection <input type="radio"/> Y-Intersection <input type="radio"/> Circle/Roundabout <input type="radio"/> Five Point or More <input type="radio"/> Interchange <input type="radio"/> Ramp School Zone <input type="radio"/> Yes <input type="radio"/> No Surface Condition <input type="radio"/> Dry <input type="radio"/> Wet <input type="radio"/> Muddy <input type="radio"/> Snow/Slush <input type="radio"/> Ice <input type="radio"/> Loose Material on Road (Gravel etc.) <input type="radio"/> Water (Standing or Moving) Road Character <input type="radio"/> Straight/Level <input type="radio"/> Straight/Grade <input type="radio"/> Straight/Hillcrest <input type="radio"/> Curve/Level <input type="radio"/> Curve/Grade <input type="radio"/> Curve/Hillcrest <input type="radio"/> Non-Roadway Crash Rumble Strips <input type="radio"/> Yes <input type="radio"/> No Construction <input type="radio"/> Yes* <input type="radio"/> No <input type="radio"/> Back-up Construction Type <input type="radio"/> Lane Closure <input type="radio"/> X-Over/Lane Shift <input type="radio"/> Work on Shoulder <input type="radio"/> Intermittent or Moving Work Roadway Type <input type="radio"/> Asphalt <input type="radio"/> Concrete <input type="radio"/> Gravel <input type="radio"/> Other Was this crash a result of aggressive driving? <input type="radio"/> Yes <input type="radio"/> No Traffic Control Devices <input type="radio"/> Officer/Crossing Guard/Flagman <input type="radio"/> RR Crossing Gate/Flagman <input type="radio"/> RR Crossing Flashing Signal <input type="radio"/> RR Crossing Sign <input type="radio"/> Traffic Control Signal <input type="radio"/> Flashing Signal <input type="radio"/> Stop Sign <input type="radio"/> Yield Sign <input type="radio"/> Lane Control <input type="radio"/> No Passing Zone <input type="radio"/> Other (Explain in Narrative) <input type="radio"/> None Traffic Control Device Operational? <input type="radio"/> Yes <input type="radio"/> No					
Total Property Damage (Include Cargo)													
Total damage in the Crash: \$750 <input type="radio"/> \$1001-\$2500 <input type="radio"/> \$5001-\$10,000 <input type="radio"/> \$25,001-\$50,000 \$100 <input type="radio"/> \$2501-\$5000 <input type="radio"/> \$10,001-\$25,000 <input type="radio"/> \$50,001-\$100,000 <input type="radio"/> Over \$100,000													
Owner Property Damage (Include Cargo)													
State <input type="radio"/> Yes <input type="radio"/> No Owner's Name and Address													
State <input type="radio"/> Yes <input type="radio"/> No Owner's Name and Address													
Witness/Other Participant													
Non-Motorist (Last Name, First Name, MI)													
Non-Motorist Action													
Apparent Physical Condition													
Non-Motorist													
Cited? <input type="radio"/> Yes <input type="radio"/> No													
Direction													
Street/Highway													
Traffic Control? <input type="radio"/> Yes <input type="radio"/> No													
If yes, what traffic control?													

The bottom of the page contains the contact information for witnesses who saw your crash, as well as information about any pedestrians or other non-motorists injured in your accident.

HOW TO READ YOUR

The top of this page contains a brief section for the investigating officer to indicate what type of crash you were involved in. The choices include "rear-end," "head-on" and several other options. Just below this section, there's a large space where the investigating police officer can draw a diagram of your accident. Make sure the vehicles' location, direction of travel and point of impact are correct.

The bottom of this page is one of the most important sections in your accident report. Here, the investigating officer writes a narrative describing your crash. The officer's narrative is often based on statements made by yourself and anyone else involved in the crash. If you disagree with the officer's description of your crash, our legal team can work with you to set the record straight.

						Page		of	
Local ID									

<input type="radio"/> Rear End <input type="radio"/> Head On <input type="radio"/> Rear to Rear	<input type="radio"/> Same Direction Sideswipe <input type="radio"/> Opposite Direction Sideswipe <input type="radio"/> Ran off Road	<input type="radio"/> Right Angle <input type="radio"/> Left Turn <input type="radio"/> Right Turn	<input type="radio"/> Backing Crash <input type="radio"/> Other <input type="radio"/> Non-Collision	 <input type="radio"/> Left/Right Turn
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m (Indicate North by Arrow)

Narrative

<input type="radio"/> AM <input type="radio"/> PM	Time Arrived	<input type="radio"/> AM <input type="radio"/> PM	Other Location of Investigation
Officer	ID No.	Agency	Investigation Complete? <input type="radio"/> Yes <input type="radio"/> No
Officer	ID No.	Agency	Photos Taken? <input type="radio"/> Yes <input type="radio"/> No
Officer (printed)	ID No.	Agency	Date of Report
			Reviewing Officer

HOW TO READ YOUR INDIANA ACCIDENT REPORT

This page contains information about each driver involved in the accident. If there were more than two vehicles involved, there will be more than two sections filled out for your multiple vehicle accident.

Along with personal information about each driver, the investigating officer will note whether the drivers were wearing their seatbelt, appeared under the influence of alcohol or if they were asleep at the wheel at the time of the crash. The officer will also note if they administered a blood alcohol test and the results of such tests. There's also space for a description of the severity of the injuries sustained by each driver and the body location of their injuries (head, neck, back, etc.). Our legal team can help carefully review all this information for accuracy.

Local ID		000012345		Page <input type="text"/> of <input type="text"/>	
Driver's Name (Last, First, MI)		Safety Equipment Used		Safety Equipment Effective?	
City, State, Zip		<input type="checkbox"/> No restraint <input type="checkbox"/> Lap Belt Only <input type="checkbox"/> Harness <input type="checkbox"/> Child Restraint <input type="checkbox"/> Helmet <input type="checkbox"/> Airbag (No Restraint) <input type="checkbox"/> Airbag + Harness <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Date of Birth: Month Day Year		CDL Class		Ejection/Trapped	
Age		Lic State		<input type="checkbox"/> Not Ejected or Trapped <input type="checkbox"/> Partially Ejected <input type="checkbox"/> Ejected <input type="checkbox"/> Trapped In <input type="checkbox"/> Pinned Under <input type="checkbox"/> Unknown	
Medical Status		Restrictions		Nature of Most Severe Injury	
<input type="checkbox"/> Glasses/Contact Lenses <input type="checkbox"/> Outside Rearview Mirror <input type="checkbox"/> Daylight Driving <input type="checkbox"/> Automatic Transmission <input type="checkbox"/> Special Controls <input type="checkbox"/> Employment Only <input type="checkbox"/> Motorcycle Only <input type="checkbox"/> To/From Employment		<input type="checkbox"/> Employer's Vehicle Only <input type="checkbox"/> State-Owned Vehicles Only <input type="checkbox"/> PP Chauffeurs/Taxi Only <input type="checkbox"/> Power Steering <input type="checkbox"/> Special Restrictions <input type="checkbox"/> Probation DWI <input type="checkbox"/> Probation HTD <input type="checkbox"/> None		<input type="checkbox"/> Severed <input type="checkbox"/> Internal <input type="checkbox"/> Minor Burn <input type="checkbox"/> Severe Burn <input type="checkbox"/> Abrasion <input type="checkbox"/> Minor Bleeding <input type="checkbox"/> Severe Bleeding (Arterial) <input type="checkbox"/> Fracture/Dislocation <input type="checkbox"/> Contusion/Bruise <input type="checkbox"/> Complaint of Pain <input type="checkbox"/> None Visible <input type="checkbox"/> Other (Explain in Narrative)	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Test Given: <input type="checkbox"/> None <input type="checkbox"/> Alcohol <input type="checkbox"/> Drug <input type="checkbox"/> Alcohol+Drug <input type="checkbox"/> Refused		Location of Most Severe Injury	
Type Given: <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Breath <input type="checkbox"/> SFST <input type="checkbox"/> PBT		Results: <input type="checkbox"/> Alcohol <input type="checkbox"/> Drug <input type="checkbox"/> Pending		<input type="checkbox"/> Chest <input type="checkbox"/> Neck <input type="checkbox"/> Eye <input type="checkbox"/> Face <input type="checkbox"/> Head <input type="checkbox"/> Back <input type="checkbox"/> Shoulder/Upper Arm <input type="checkbox"/> Elbow/Lower Arm <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Hip/Upper Leg <input type="checkbox"/> Knee/Lower Leg/Foot <input type="checkbox"/> Entire Body	
Vehicle Year Make Model Name Style		Initial Impact Area		Areas Damaged (Multiples)	
Lic Year License # License State		<input type="checkbox"/> Undercarriage <input type="checkbox"/> Trailer <input type="checkbox"/> None <input type="checkbox"/> Unknown		<input type="checkbox"/> Undercarriage <input type="checkbox"/> Trailer <input type="checkbox"/> None <input type="checkbox"/> Unknown	
Limit Insured By		Vehicle Use		*Emergency Run?	
Phone Number		<input type="checkbox"/> Personal (Farm, Company) <input type="checkbox"/> Commercial (Buses, Taxis, Common and Contract Carriers) <input type="checkbox"/> Rental, not leased <input type="checkbox"/> School <input type="checkbox"/> Police		<input type="checkbox"/> Fire* <input type="checkbox"/> Ambulance* <input type="checkbox"/> Military <input type="checkbox"/> Highway Department <input type="checkbox"/> Other Government (Postal, etc) <input type="checkbox"/> Public Utilities (Gas, Electric, etc) <input type="checkbox"/> Other (Explain in Narrative)	
Owner's Name (Last, First, MI) <input type="checkbox"/> Same as Driver		Vehicle Type		<input type="checkbox"/> Yes <input type="checkbox"/> No	
City, State, Zip		<input type="checkbox"/> Passenger Car/Station Wagon <input type="checkbox"/> Pickup <input type="checkbox"/> Van <input type="checkbox"/> Sport Utility Vehicle <input type="checkbox"/> Truck (Single Unit 2 axle, 6 tires) <input type="checkbox"/> Truck (Single Unit 3 or more axles) <input type="checkbox"/> Truck/Trailer (not semi) <input type="checkbox"/> Tractor/One Semi Trailer <input type="checkbox"/> Tractor/Double Trailers <input type="checkbox"/> Tractor/Triple Trailers		<input type="checkbox"/> Fire? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Towed To Towed By		Pre-Crash Vehicle Action		Direction of Travel	
Lic Year Registered Owner's Name (Last, First, MI)		<input type="checkbox"/> Going Straight <input type="checkbox"/> Backing <input type="checkbox"/> Changing Lanes <input type="checkbox"/> Overtaking/Passing <input type="checkbox"/> Turning Right		<input type="checkbox"/> Turning Left <input type="checkbox"/> Making U Turn <input type="checkbox"/> Merging <input type="checkbox"/> Starting in Traffic <input type="checkbox"/> Driving Left of Center <input type="checkbox"/> Crossing the Median	
Address (Street, City, State, Zip)		<input type="checkbox"/> Slowing or Stopped in Traffic <input type="checkbox"/> Unattended Moving Vehicle <input type="checkbox"/> Avoiding Object in Road <input type="checkbox"/> Entering Traffic Lane <input type="checkbox"/> Leaving Traffic Lane <input type="checkbox"/> Parked		<input type="checkbox"/> North <input type="checkbox"/> East <input type="checkbox"/> Northeast <input type="checkbox"/> Southeast <input type="checkbox"/> South <input type="checkbox"/> West <input type="checkbox"/> Northwest <input type="checkbox"/> Southwest	
Commercial Vehicle: Carrier's Name and Address		Type of Primary/Secondary Roadway		If a Collision Crash Fill in only one oval in this category	
One Way Traffic: <input type="checkbox"/> One Lane <input type="checkbox"/> Two Lanes <input type="checkbox"/> Multi-Lanes (3 or more)		Two Way Traffic: <input type="checkbox"/> Two Lanes <input type="checkbox"/> Multi-Lane Divided (3 or more) <input type="checkbox"/> Multi-Lane Undivided 2way left turn <input type="checkbox"/> Multi-Lane Undivided (3 or more)		<input type="checkbox"/> Another Motor Vehicle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Bicycle <input type="checkbox"/> Impact Attenuator/Crash Cushion <input type="checkbox"/> Bridge Overhead Structure <input type="checkbox"/> Bridge Pier or Abutment <input type="checkbox"/> Bridge Parapet End <input type="checkbox"/> Bridge Rail <input type="checkbox"/> Guardrail Face <input type="checkbox"/> Guardrail End <input type="checkbox"/> Median Barrier <input type="checkbox"/> Highway Traffic Sign Post	
Shipping Name:		If a Non-Collision Crash Fill in only one oval in this category		<input type="checkbox"/> Deer <input type="checkbox"/> Animal Other than Deer <input type="checkbox"/> Animal Drawn Vehicle <input type="checkbox"/> Overhead Sign Post <input type="checkbox"/> Light Support <input type="checkbox"/> Utility Pole <input type="checkbox"/> Culvert <input type="checkbox"/> Embankment <input type="checkbox"/> Other Post/Pole/or Support <input type="checkbox"/> Wall/Building/Tunnel, etc <input type="checkbox"/> Work Zone Maintenance Equip <input type="checkbox"/> Other (explain in narrative)	
US DOT# ICC# State DOT#		Vehicle Identification#		Or if a Non-Collision Crash Fill in only one oval in this category	
CMV Inspection? <input type="checkbox"/> Yes <input type="checkbox"/> No		If <input type="checkbox"/> L1 <input type="checkbox"/> L3		<input type="checkbox"/> Overturn/Rollover <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Immersion <input type="checkbox"/> Jackknife <input type="checkbox"/> Cargo/Equipment Shift or Loss <input type="checkbox"/> Off Roadway <input type="checkbox"/> Fell from vehicle	
Gross Vehicle Weight Rating: <input type="checkbox"/> Less than 10,000# <input type="checkbox"/> 10,001-26,000# <input type="checkbox"/> 26,001# or more		Cargo Body Type: <input type="checkbox"/> Grain, Chip, Gravel, Coal <input type="checkbox"/> Flatbed <input type="checkbox"/> Dump <input type="checkbox"/> Bus <input type="checkbox"/> Van/Enclosed Box <input type="checkbox"/> Cargo Tank <input type="checkbox"/> Garbage/Refuse <input type="checkbox"/> Concrete Mixer <input type="checkbox"/> Auto Transport <input type="checkbox"/> Pole <input type="checkbox"/> Other (Explain in Narrative)			
HAZMAT <input type="checkbox"/> Yes <input type="checkbox"/> No		HAZMAT Release of Cargo <input type="checkbox"/> Yes <input type="checkbox"/> No		HAZMAT 4-Digit ID # Hazard Class #	

HOW TO READ YOUR INDIANA ACCIDENT REPORT

This page is reserved for information about any non-motorists involved in your accident, including passengers, pedestrians and cyclists. As with the information on page three about all drivers involved in the crash, the investigating police officer will note what type of injury each non-motorist sustained, whether they were wearing a seatbelt and whether they appeared intoxicated at the time of the accident investigation.

Local ID		Page <input type="text"/> of <input type="text"/>	
Crash Location: Veh# <input type="text"/> <input type="radio"/> Pedalcyclist <input type="radio"/> Pedestrian <input type="radio"/> Other (Explain in Narrative)		Safety Equipment Used	
Address (Last, First, MI) Address, etc.		<input type="radio"/> No restraint <input type="radio"/> Lap Belt Only <input type="radio"/> Harness <input type="radio"/> Child Restraint <input type="radio"/> Helmet <input type="radio"/> Airbag (No Restraint) <input type="radio"/> Airbag + Harness <input type="radio"/> Unknown	
Day <input type="text"/> Year <input type="text"/> Age <input type="text"/>		Safety Equipment Effective?	
Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
Position in or on Vehicle		Ejection/Trapped	
<input type="radio"/> Front <input type="radio"/> Rear		<input type="radio"/> Not Ejected or Trapped <input type="radio"/> Partially Ejected <input type="radio"/> Ejected <input type="radio"/> Trapped In <input type="radio"/> Pinned Under <input type="radio"/> Unknown	
Victim Injury Status		Nature of Most Severe Injury	
<input type="radio"/> Fatal Injury <input type="radio"/> Non Fatal Injury <input type="radio"/> Incapacitating <input type="radio"/> Non-Incapacitating <input type="radio"/> Unknown <input type="radio"/> Refused		<input type="radio"/> Severed <input type="radio"/> Minor Burn <input type="radio"/> Internal <input type="radio"/> Severe Burn <input type="radio"/> Abrasion <input type="radio"/> Minor Bleeding <input type="radio"/> Severe Bleeding (Arterial) <input type="radio"/> Fracture/Dislocation <input type="radio"/> Contusion/Bruise <input type="radio"/> Complaint of Pain <input type="radio"/> None Visible <input type="radio"/> Other (Explain in Narrative)	
EMS No. <input type="text"/>		Location of Most Severe Injury	
		<input type="radio"/> Head <input type="radio"/> Face <input type="radio"/> Eye <input type="radio"/> Neck <input type="radio"/> Chest <input type="radio"/> Back <input type="radio"/> Shoulder/Upper Arm <input type="radio"/> Elbow/Lower Arm <input type="radio"/> Abdoman/Pelvis <input type="radio"/> Hip/Upper Leg <input type="radio"/> Knee/LowerLeg/Foot <input type="radio"/> Entire Body	
		Test Given	
		<input type="radio"/> None <input type="radio"/> Alcohol <input type="radio"/> Drug <input type="radio"/> Alcohol+Drug <input type="radio"/> Refused	
		Type Given	
		<input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> Breath <input type="radio"/> SFST <input type="radio"/> PBT	
		Results	
		<input type="radio"/> Alcohol <input type="radio"/> Drug <input type="radio"/> Pending <input type="radio"/>	
Crash Location: Veh# <input type="text"/> <input type="radio"/> Pedalcyclist <input type="radio"/> Pedestrian <input type="radio"/> Other (Explain in Narrative)		Safety Equipment Used	
Address (Last, First, MI) Address, etc.		<input type="radio"/> No restraint <input type="radio"/> Lap Belt Only <input type="radio"/> Harness <input type="radio"/> Child Restraint <input type="radio"/> Helmet <input type="radio"/> Airbag (No Restraint) <input type="radio"/> Airbag + Harness <input type="radio"/> Unknown	
Day <input type="text"/> Year <input type="text"/> Age <input type="text"/>		Safety Equipment Effective?	
Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
Position in or on Vehicle		Ejection/Trapped	
<input type="radio"/> Front <input type="radio"/> Rear		<input type="radio"/> Not Ejected or Trapped <input type="radio"/> Partially Ejected <input type="radio"/> Ejected <input type="radio"/> Trapped In <input type="radio"/> Pinned Under <input type="radio"/> Unknown	
Victim Injury Status		Nature of Most Severe Injury	
<input type="radio"/> Fatal Injury <input type="radio"/> Non Fatal Injury <input type="radio"/> Incapacitating <input type="radio"/> Non-Incapacitating <input type="radio"/> Unknown <input type="radio"/> Refused		<input type="radio"/> Severed <input type="radio"/> Minor Burn <input type="radio"/> Internal <input type="radio"/> Severe Burn <input type="radio"/> Abrasion <input type="radio"/> Minor Bleeding <input type="radio"/> Severe Bleeding (Arterial) <input type="radio"/> Fracture/Dislocation <input type="radio"/> Contusion/Bruise <input type="radio"/> Complaint of Pain <input type="radio"/> None Visible <input type="radio"/> Other (Explain in Narrative)	
EMS No. <input type="text"/>		Location of Most Severe Injury	
		<input type="radio"/> Head <input type="radio"/> Face <input type="radio"/> Eye <input type="radio"/> Neck <input type="radio"/> Chest <input type="radio"/> Back <input type="radio"/> Shoulder/Upper Arm <input type="radio"/> Elbow/Lower Arm <input type="radio"/> Abdoman/Pelvis <input type="radio"/> Hip/Upper Leg <input type="radio"/> Knee/LowerLeg/Foot <input type="radio"/> Entire Body	
		Test Given	
		<input type="radio"/> None <input type="radio"/> Alcohol <input type="radio"/> Drug <input type="radio"/> Alcohol+Drug <input type="radio"/> Refused	
		Type Given	
		<input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> Breath <input type="radio"/> SFST <input type="radio"/> PBT	
		Results	
		<input type="radio"/> Alcohol <input type="radio"/> Drug <input type="radio"/> Pending <input type="radio"/>	
Injured Pre-crash Location: Veh# <input type="text"/> <input type="radio"/> Pedalcyclist <input type="radio"/> Pedestrian <input type="radio"/> Other (Explain in Narrative)		Safety Equipment Used	
Name (Last, First, MI) Address, etc.		<input type="radio"/> No restraint <input type="radio"/> Lap Belt Only <input type="radio"/> Harness <input type="radio"/> Child Restraint <input type="radio"/> Helmet <input type="radio"/> Airbag (No Restraint) <input type="radio"/> Airbag + Harness <input type="radio"/> Unknown	
Date of Birth <input type="text"/> Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> Age <input type="text"/>		Safety Equipment Effective?	
Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
Position in or on Vehicle		Ejection/Trapped	
<input type="radio"/> Front <input type="radio"/> Rear		<input type="radio"/> Not Ejected or Trapped <input type="radio"/> Partially Ejected <input type="radio"/> Ejected <input type="radio"/> Trapped In <input type="radio"/> Pinned Under <input type="radio"/> Unknown	
Victim Injury Status		Nature of Most Severe Injury	
<input type="radio"/> Fatal Injury <input type="radio"/> Non Fatal Injury <input type="radio"/> Incapacitating <input type="radio"/> Non-Incapacitating <input type="radio"/> Unknown <input type="radio"/> Refused		<input type="radio"/> Severed <input type="radio"/> Minor Burn <input type="radio"/> Internal <input type="radio"/> Severe Burn <input type="radio"/> Abrasion <input type="radio"/> Minor Bleeding <input type="radio"/> Severe Bleeding (Arterial) <input type="radio"/> Fracture/Dislocation <input type="radio"/> Contusion/Bruise <input type="radio"/> Complaint of Pain <input type="radio"/> None Visible <input type="radio"/> Other (Explain in Narrative)	
EMS No. <input type="text"/>		Location of Most Severe Injury	
		<input type="radio"/> Head <input type="radio"/> Face <input type="radio"/> Eye <input type="radio"/> Neck <input type="radio"/> Chest <input type="radio"/> Back <input type="radio"/> Shoulder/Upper Arm <input type="radio"/> Elbow/Lower Arm <input type="radio"/> Abdoman/Pelvis <input type="radio"/> Hip/Upper Leg <input type="radio"/> Knee/LowerLeg/Foot <input type="radio"/> Entire Body	
		Test Given	
		<input type="radio"/> None <input type="radio"/> Alcohol <input type="radio"/> Drug <input type="radio"/> Alcohol+Drug <input type="radio"/> Refused	
		Type Given	
		<input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> Breath <input type="radio"/> SFST <input type="radio"/> PBT	
		Results	
		<input type="radio"/> Alcohol <input type="radio"/> Drug <input type="radio"/> Pending <input type="radio"/>	
Injured Pre-crash Location: Veh# <input type="text"/> <input type="radio"/> Pedalcyclist <input type="radio"/> Pedestrian <input type="radio"/> Other (Explain in Narrative)		Safety Equipment Used	
Name (Last, First, MI) Address, etc.		<input type="radio"/> No restraint <input type="radio"/> Lap Belt Only <input type="radio"/> Harness <input type="radio"/> Child Restraint <input type="radio"/> Helmet <input type="radio"/> Airbag (No Restraint) <input type="radio"/> Airbag + Harness <input type="radio"/> Unknown	
Date of Birth <input type="text"/> Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> Age <input type="text"/>		Safety Equipment Effective?	
Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
Position in or on Vehicle		Ejection/Trapped	
<input type="radio"/> Front <input type="radio"/> Rear		<input type="radio"/> Not Ejected or Trapped <input type="radio"/> Partially Ejected <input type="radio"/> Ejected <input type="radio"/> Trapped In <input type="radio"/> Pinned Under <input type="radio"/> Unknown	
Victim Injury Status		Nature of Most Severe Injury	
<input type="radio"/> Fatal Injury <input type="radio"/> Non Fatal Injury <input type="radio"/> Incapacitating <input type="radio"/> Non-Incapacitating <input type="radio"/> Unknown <input type="radio"/> Refused		<input type="radio"/> Severed <input type="radio"/> Minor Burn <input type="radio"/> Internal <input type="radio"/> Severe Burn <input type="radio"/> Abrasion <input type="radio"/> Minor Bleeding <input type="radio"/> Severe Bleeding (Arterial) <input type="radio"/> Fracture/Dislocation <input type="radio"/> Contusion/Bruise <input type="radio"/> Complaint of Pain <input type="radio"/> None Visible <input type="radio"/> Other (Explain in Narrative)	
EMS No. <input type="text"/>		Location of Most Severe Injury	
		<input type="radio"/> Head <input type="radio"/> Face <input type="radio"/> Eye <input type="radio"/> Neck <input type="radio"/> Chest <input type="radio"/> Back <input type="radio"/> Shoulder/Upper Arm <input type="radio"/> Elbow/Lower Arm <input type="radio"/> Abdoman/Pelvis <input type="radio"/> Hip/Upper Leg <input type="radio"/> Knee/LowerLeg/Foot <input type="radio"/> Entire Body	
		Test Given	
		<input type="radio"/> None <input type="radio"/> Alcohol <input type="radio"/> Drug <input type="radio"/> Alcohol+Drug <input type="radio"/> Refused	
		Type Given	
		<input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> Breath <input type="radio"/> SFST <input type="radio"/> PBT	
		Results	
		<input type="radio"/> Alcohol <input type="radio"/> Drug <input type="radio"/> Pending <input type="radio"/>	