



ZURICH MUNICIPAL

22/05/2006 13:56

PERSONAL ACCIDENT REPORT FORM

PLEASE ANSWER EVERY QUESTION.

PLEASE REPLY TO:

Policy Number	OLA 14U005 0013	Claim Number	Q14014929	Department concerned
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INSURED

Name	The Highland Council		
Address	Council Headquarters Glenurquhart Road		
Inverness		Post code	IV3 5NX
Telephone Number	(01463) 702417	Occupation	

INJURED PERSON

Name	
Private Address	
Present business or occupation	Department

ACCIDENT

When did accident occur?	Date	Time	am/pm
Where did accident occur?			
How did accident happen?			
What were you doing at the time?			
Give names and addresses of all witnesses of the accident			

INJURIES

State as fully as possible what injuries you have sustained	
Have you had an injury to the same part before?	If so, give details
Give name and address of medical practitioner attending you for the injuries	
Is he/she your usual Medical Attendant?	If not, state what he/she is in attendance

INCAPACITY

Have you as the direct result of the accident been totally incapacitated from attending to business of any kind?

If so, give date total incapacity commenced

During what period have you been confined to:

Bed:	From:	To:	House:	From:	To:
					Date:

Are you now able to attend to any portion of your business?

When and where can you be visited by our Doctor or other representative?

The Insured must arrange at their own expense for the completion of this certificate by a qualified and registered Medical Practitioner.

To comply with the "Access to Medical Reports Act 1988", the certificate should be returned to the injured person before being sent on to the company at the address overleaf.

Re: (patient's name)

When did you first attend the patient in respect of his/her accident?

Are you still in attendance?

Are you the patient's usual Medical Attendant?

If so, for how long has he/she been your patient?

State in detail the nature and extent of injuries (if limb injured state whether left or right)

Are the symptoms from which the patient suffers due to: (a) The accident only? (b) Any other cause?

Is the patient now, or was he/she at the time of the accident, subject to or suffering from any illness irrespective of the injuries?

If so, state the nature of same and the extent to which recovery of patient from the accident may be affected hereby.

Are you aware of any past accident or illness, which directly or indirectly may have contributed to or may retard the patient's recovery?

Have you any reason to believe the patient was not sober at the time of the accident?

Is the patient confined to bed or residence on your instructions?

If so, what is likely to be the probable period of total incapacity?

Doctors Signature

Date:

Doctor's Name:

Qualifications:

Doctors Address