

REPORT OF INJURY

(AR 27-20)

PRIVACY ACT STATEMENT: AUTHORITY - 5USC301, 10USC3012, 42USC2651, EXECUTIVE ORDER 9397. PRINCIPAL PURPOSE(S) - TO PROVIDE INFORMATION NECESSARY TO ENABLE THE GOVERNMENT TO RECOVER THE REASONABLE VALUE OF MEDICAL CARE FURNISHED AT ITS EXPENSE AS THE RESULT OF INJURIES RECEIVED FROM TORTFEASORS. ROUTINE USES - IDENTIFY INJURED PARTY AND NATURE OF INJURIES. IDENTIFY OTHER PERSONS INVOLVED INCLUDING WITNESSES. DETERMINE THE CIRCUMSTANCES OF INCIDENTS WHICH GIVE RISE TO PERSONAL INJURIES. SSN USED FOR IDENTIFICATION PURPOSES WHEN REQUESTING INFORMATION FROM OTHER AGENCIES. DISCLOSURE - VOLUNTARY; HOWEVER, FAILURE TO PROVIDE REQUESTED INFORMATION WILL RESULT IN WITHHOLDING OF ALL MEDICAL RECORDS PERTAINING TO MEDICAL HISTORY, DIAGNOSES, FINDINGS, AND TREATMENT FROM THE INJURED PARTY OR THEIR REPRESENTATIVE.

INSTRUCTIONS: PURSUANT TO ARMY REGULATION 27-20 AND 40-16, JUDGE ADVOCATE PERSONNEL AND MEDICAL DEPARTMENT PERSONNEL ARE REQUIRED TO OBTAIN INFORMATION CONCERNING THE CIRCUMSTANCES SURROUNDING THE INJURIES OF PERSONS RECEIVING MEDICAL CARE AT GOVERNMENT EXPENSE. THESE REGULATIONS APPLY EQUALLY TO ACTIVE OR RETIRED PERSONNEL AND THEIR DEPENDENTS.

1. PLEASE FILL OUT THIS FORM COMPLETELY AND ANSWER ALL QUESTIONS. IF ANSWER IS UNKNOWN OR NOT APPLICABLE, SO STATE.
2. USE LAST PAGE OR ADDITIONAL SHEETS OF PAPER TO AMPLIFY YOUR ANSWERS.
3. DESCRIBE INJURIES AND DRAW DIAGRAM IF MOTOR VEHICLE ACCIDENT (MVA). BE SURE TO FURNISH COMPLETE INSURANCE INFORMATION REGARDING YOUR OWN VEHICLE EVEN THOUGH THIS WAS A ONE-CAR ACCIDENT OR A "HIT AND RUN" ACCIDENT.

SECTION I - INJURED PARTY

LAST NAME - FIRST - MI	GRADE	SSN
ORGANIZATION	TELEPHONE	
PERMANENT HOME ADDRESS	TELEPHONE	
PRESENT RESIDENCE ADDRESS	TELEPHONE	
DATE OF BIRTH	STATUS [] ACTIVE [] RETIRED [] DEPENDENT	IF ON ACTIVE DUTY, GIVE ESTIMATED DATE OF TRANSFER OR SEPARATION

SECTION II - SPONSOR INFORMATION

LAST NAME - FIRST- MI	GRADE	SSN
ORGANIZATION	TELEPHONE	
PRESENT RESIDENCE ADDRESS	TELEPHONE	
PERMANENT HOME ADDRESS	TELEPHONE	
IF ON ACTIVE DUTY, GIVE ESTIMATED DATE OF TRANSFER OR SEPARATION	STATUS [] ACTIVE [] RETIRED	

SECTION III - BASIC DETAILS

DATE AND TIME OF ACCIDENT	LOCATION (STREET, CITY, COUNTY, STATE)
WAS A POLICE INVESTIGATION CONDUCTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF POLICE DEPARTMENT _____	
WHO RECEIVED A CITATION? _____	
WHAT WAS THE CHARGE? _____	
IF YOU HAVE CONSULTED AN ATTORNEY IN CONNECTION WITH THIS ACCIDENT, GIVE THEIR NAME AND ADDRESS. _____	

TYPE OF INCIDENT

<input type="checkbox"/> MOTOR VEHICLE ACCIDENT	IF MOTOR VEHICLE ACCIDENT, COMPLETE SECTIONS IV, VII & VIII.
<input type="checkbox"/> ON THE JOB INJURIES	IF ON THE JOB, COMPLETE SECTIONS V, VII, & VIII.
<input type="checkbox"/> ASSAULT	IF ASSAULT, COMPLETE SECTIONS VI, VII, & VIII.
<input type="checkbox"/> OTHER	COMPLETE SECTIONS VI, VII, & VIII
NAME OF ASSAILANT _____	
SPECIFY TYPE _____	

WITNESSES

NAME & ADDRESS
NAME & ADDRESS

SECTION IV - MOTOR VEHICLE INJURIES

PART A - VEHICLE YOU WERE RIDING IN

NAME OF DRIVER		ADDRESS		
NAME OF OWNER		ADDRESS		
OTHER PASSENGERS NAME		ADDRESS OR ORGANIZATION		INJURED <input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER PASSENGERS NAME		ADDRESS OR ORGANIZATION		INJURED <input type="checkbox"/> YES <input type="checkbox"/> NO
VEHICLE MAKE	VEHICLE MODEL	LICENSE NO.	STATE	MILITARY DECAL NO.

PART B - OTHER VEHICLE

NAME OF DRIVER		ADDRESS		
NAME OF OWNER		ADDRESS		
OTHER PASSENGERS NAME		ADDRESS OR ORGANIZATION		INJURED <input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER PASSENGERS NAME		ADDRESS OR ORGANIZATION		INJURED <input type="checkbox"/> YES <input type="checkbox"/> NO
VEHICLE MAKE	VEHICLE MODEL	LICENSE NO.	STATE	MILITARY DECAL NO.

PART C - INSURANCE DATA

1. GIVE NAME AND ADDRESS OF ANY HOSPITALIZATION INSURANCE YOU MAY CARRY.		
2. GIVE NAME AND ADDRESS OF INSURANCE COMPANY FOR THE <u>VEHICLE YOU WERE IN</u> .		
DOES THE POLICY HAVE PERSONAL INJURY PROTECTION COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL PAYMENTS COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	UNINSURED MOTORISTS COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
POLICY NO.:	EXPIRATION DATE:	
3. GIVE NAME AND ADDRESS OF INSURANCE COMPANY FOR ANY <u>VEHICLE YOU OWN</u> .		
DOES THE POLICY HAVE PERSONAL INJURY PROTECTION COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL PAYMENTS COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	UNINSURED MOTORISTS COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
POLICY NO.:	EXPIRATION DATE:	
4. GIVE NAME AND ADDRESS OF INSURANCE COMPANY FOR THE <u>OTHER VEHICLE</u> .		
POLICY NO.:	EXPIRATION DATE:	
5. IF AN INSURANCE ADJUSTER HAS CONTACTED YOU, PLEASE FURNISH NAME AND ADDRESS:		
DID THE INSURANCE ADJUSTER REPRESENT-		
<input type="checkbox"/> YOUR COMPANY	<input type="checkbox"/> COMPANY INSURING THE CAR IN WHICH YOU WERE RIDING	<input type="checkbox"/> COMPANY INSURING THE OTHER VEHICLE
IF YOU HAVE GIVEN A WRITTEN STATEMENT TO ANYONE CONCERNING THIS ACCIDENT, PLEASE FURNISH A COPY OR ADVISE TO WHOM IT WAS GIVEN.		
HAVE YOU RECEIVED ANY SETTLEMENT FOR YOUR PERSONAL INJURIES? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, STATE AMOUNT. \$	HAVE YOU SIGNED A RELEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION V - ON THE JOB INJURIES

NAME AND ADDRESS OF EMPLOYER/BUSINESS	TELEPHONE
NAME AND ADDRESS OF WORKMAN'S COMPENSATION INSURANCE COMPANY	
POLICY OR CLAIM # _____	
NAME AND ADDRESS OF INSURANCE ADJUSTER	TELEPHONE

SECTION VI - NON VEHICULAR INJURIES

COMPLETE IF INJURIES DID NOT RESULT FROM A MOTOR VEHICLE ACCIDENT. IF INJURIES RESULTED FROM A VEHICLE ACCIDENT, COMPLETE SECTION IV.

PART A - LOCATION

SITE OF INJURY (STREET/PLACE, CITY, COUNTY, STATE)	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM HOUR	DATE
NAME AND ADDRESS OF OWNER OF PROPERTY WHERE INJURY OCCURRED	NAME OF OCCUPANT OF PROPERTY (IF DIFFERENT FROM OWNER)	

PART B - INSURANCE

INSURANCE COMPANY OF OWNER WHERE INJURY OCCURRED	POLICY NUMBER
ADDRESS	
NAME AND ADDRESS OF INSURANCE ADJUSTER	

PART C - PERSONS INVOLVED

NAME	ADDRESS (INCLUDE ZIP CODE) AND PHONE NO. (INCLUDE AREA CODE)
NAME	ADDRESS (INCLUDE ZIP CODE) AND PHONE NO. (INCLUDE AREA CODE)
NAME	ADDRESS (INCLUDE ZIP CODE) AND PHONE NO. (INCLUDE AREA CODE)
NAME	ADDRESS (INCLUDE ZIP CODE) AND PHONE NO. (INCLUDE AREA CODE)

SECTION VII - MEDICAL DATA

GIVE ALL DETAILS ABOUT ALL MEDICAL CARE RECEIVED BY ANYONE INJURED IN THIS ACCIDENT. INCLUDE DATES AS NEARLY AS POSSIBLE.

PART A - DESCRIPTION OF INJURIES

DESCRIBE INJURIES IN YOUR OWN WORDS

INJURED PARTY	NAME OF INSTALLATION	DATES IN HOSPITAL
		DATES OF OUTPATIENT CARE

NAME OF AMBULANCE SERVICE _____

1. ARE YOU STILL UNDER TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	2. IF YES, WHERE?
3. HAVE YOU PAID ANY OF THE CIVILIAN MEDICAL BILLS? <input type="checkbox"/> YES <input type="checkbox"/> NO	4. DO YOU KNOW IF THEY HAVE BEEN PAID? <input type="checkbox"/> YES <input type="checkbox"/> NO
5. IF YES, WHO PAID THE BILLS? (ARMY, INSURANCE COMPANY)	6. HAVE ANY CIVILIAN MEDICAL BILLS BEEN SUBMITTED TO CHAMPUS OR DO YOU PLAN TO SUBMIT ANY BILLS TO CHAMPUS? <input type="checkbox"/> YES <input type="checkbox"/> NO

PART B - MEDICAL RELEASE

IF THE INJURED PARTY IS A MINOR, PARENT OR SPONSOR SIGN BOTH BLANKS.

TO: ANY PHYSICIAN, HOSPITAL, CLINIC, OR SANITARIUM
 YOU ARE HEREBY AUTHORIZED TO RELEASE AND FURNISH TO THE UNITED STATES OF AMERICA FULL AND COMPLETE INFORMATION, INCLUDING COPIES OF ANY AND ALL MEDICAL TREATMENT RENDERED TO ME FOR USE IN PURSUING A CLAIM DUE THE UNITED STATES OF AMERICA.

DATE	SIGNATURE
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THE INFORMATION FURNISHED IS TRUE AND CORRECT.
 I ACKNOWLEDGE RECEIPT OF LETTER OF NOTIFICATION AND ADVICE TO INJURED PARTIES PURSUANT TO AR 27-20.

DATE	SIGNATURE
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SECTION VIII

TELL IN YOUR OWN WORDS JUST WHAT HAPPENED; INCLUDE A DIAGRAM IF IT WAS A VEHICLE ACCIDENT. (IF MORE SPACE IS NEEDED, USE ADDITIONAL SHEETS)