



# STATEMENT OF INCIDENT

## QUESTIONNAIRE



**INSTRUCTIONS FOR COMPLETION OF QUESTIONNAIRE**

You must provide all information that pertains to the circumstances of your injury. For sections that do not apply to you, please mark "N/A" (Not Applicable) in the space provided. Attach documents supporting your statement. Title 32 Code of Federal Regulations, Section 220.9, which requires completion of this form applies equally to active, retired, or separated United States Army personnel and/or their family members. If you are represented by an attorney, refer this questionnaire to your attorney for assistance.

\* \* \* **RETURN COMPLETED QUESTIONNAIRE TO:** \* \* \*

**Madigan Army Medical Center, ATTN: MCHJ-JA, Medical Care Recovery, Tacoma, WA 98431**

**INJURED PARTY**

<b>NAME</b> (Last, First, MI)	<b>DATE OF BIRTH</b>	<b>SOCIAL SECURITY #</b>
<b>HOME ADDRESS</b>	<b>HOME TELEPHONE</b>	<b>WORK TELEPHONE</b>

**MILITARY SPONSOR**

<b>BRANCH OF SERVICE</b>	<b>SPONSOR'S STATUS</b>
(Check One) : USA <input type="checkbox"/> USAF <input type="checkbox"/> USN <input type="checkbox"/> USMC <input type="checkbox"/> OTHER <input type="checkbox"/>	(Check One) : Active Duty <input type="checkbox"/> Retired <input type="checkbox"/> ETS'd <input type="checkbox"/> Deceased <input type="checkbox"/>
<b>NAME</b> (Last, First, MI)	<b>GRADE/RANK</b>
<b>MILITARY UNIT MAILING ADDRESS</b> (If sponsor is on active duty)	<b>SPONSOR'S SSN</b>
	<b>UNIT TELEPHONE</b>

**DETAILS OF THE INCIDENT**

<b>DATE</b>	<b>TIME</b> AM <input type="checkbox"/> PM <input type="checkbox"/>	<b>COUNTY</b>
<b>STREET</b>	<b>CITY</b>	<b>STATE</b>
<b>POLICE AGENCY INVESTIGATION ?:</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>	MILITARY <input type="checkbox"/> CIVILIAN <input type="checkbox"/>
<b>IF YES, NAME OF AGENCY</b>	<b>TRAFFIC ACCIDENT REPORT #</b>	<b>ACCIDENT REPORT ATTACHED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>WAS A CITATION ISSUED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>IF YES, TO WHOM</b>	<b>CITED FOR</b>

**IN YOUR OWN WORDS, please describe below : (1) The circumstances of exactly how the incident occurred, (2) How you came to be injured, and (3) Who (if anyone) was at fault. (Please PRINT)**

### MOTOR VEHICLE ACCIDENTS

**IMPORTANT:** Notify your own insurance carrier even though the injured party was a pedestrian, a passenger in another vehicle, a victim of a "hit and run" incident, a bicyclist, or was involved in a one-vehicle accident. Failure to do so may jeopardize any right of recovery you have or the rights of the United States Government. Direct any questions to the Office of the Staff Judge Advocate.

<b>I WAS A:</b>	<b>DRIVER</b> <input type="checkbox"/>	<b>PASSENGER</b> <input type="checkbox"/>	<b>PEDESTRIAN</b> <input type="checkbox"/>	<b>BICYCLIST</b> <input type="checkbox"/>	<b>OTHER</b> <input type="checkbox"/>
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YOUR VEHICLE	YEAR	MAKE	MODEL
<b>NAME OF DRIVER</b>		<b>ADDRESS</b>	
<b>NAME OF OWNER</b> (if different than driver)		<b>ADDRESS</b>	
<b>INSURANCE COMPANY</b>		<b>ADDRESS</b>	
<b>CLAIMS #:</b>		<b>CLAIMS ADJUSTER:</b>	
<b>IS A COPY OF THE AUTO POLICY ATTACHED ? :</b>		<b>Y E S</b> <input type="checkbox"/>	<b>N O</b> <input type="checkbox"/>
<b>TYPES OF POLICY COVERAGE:</b> Check (3) all types that apply and indicate coverage amounts:	<input type="checkbox"/> Personal Injury Protection (PIP) Coverage Amount \$ _____	<input type="checkbox"/> Medical Payments (MedPay) Coverage Amount \$ _____	<input type="checkbox"/> Uninsured/Underinsured Motorist (UM/UIM) Coverage Amount \$ _____

THE OTHER VEHICLE	YEAR	MAKE	MODEL
<b>NAME OF OTHER DRIVER</b>		<b>ADDRESS</b>	
<b>NAME OF OTHER VEHICLE'S OWNER</b>		<b>ADDRESS</b>	
<b>OTHER DRIVER'S INSURANCE COMPANY</b>		<b>ADDRESS</b>	
<b>CLAIMS #:</b>		<b>CLAIMS ADJUSTER:</b>	

### WORKER'S COMPENSATION CLAIM

<b>NAME OF BUSINESS/ORGANIZATION</b>	<b>ADDRESS</b>
<b>EMPLOYER'S INSURANCE COMPANY</b>	<b>ADDRESS</b>
<b>NAME OF CLAIMS ADJUSTER</b>	<b>CLAIMS ADJUSTER'S TELEPHONE NUMBER</b>
<b>WORKER'S COMPENSATION CLAIM NUMBER:</b>	<b>OTHER INFORMATION:</b>

### OTHER TYPES OF INCIDENTS

<b>INJURY OCCURRED AT:</b>	<b>MY HOME</b> <input type="checkbox"/>	<b>OTHER RESIDENCE</b> <input type="checkbox"/>	<b>SCHOOL</b> <input type="checkbox"/>	<b>PUBLIC PROPERTY</b> <input type="checkbox"/>	<b>PRIVATE PROPERTY</b> <input type="checkbox"/>
<b>NAME OF PROPERTY OWNER</b>		<b>ADDRESS</b>			
<b>NAME OF INSURANCE COMPANY</b>		<b>ADDRESS</b>			
<b>NAME OF CLAIM ADJUSTER</b>		<b>CLAIM ADJUSTER'S TELEPHONE NUMBER</b>			
<b>INSURANCE POLICY NUMBER:</b>		<b>INSURANCE CLAIM NUMBER:</b>			

**MEDICAL CONDITION**

DESCRIBE BELOW WHAT INJURY or INJURIES WERE EVALUATED OR TREATED AS A RESULT OF THIS INCIDENT:

(Please *be specific* when describing the nature and severity of your illness/injuries, being careful to include "Left" or "Right", when specifying bodily location. Also indicate if any surgeries or tests have been performed or *will be* performed).

LIST BELOW THE NAMES OF **MILITARY FACILITIES** PROVIDING MEDICAL CARE AS A RESULT OF THIS INCIDENT:

**MILITARY MEDICAL FACILITY(IES):**

Other Military Facility  
(Please specify) :

LIST BELOW THE NAMES OF **CIVILIAN FACILITIES** PROVIDING MEDICAL CARE AS A RESULT OF THIS INCIDENT:

**NON-MILITARY MEDICAL FACILITY(IES):**

(or Doctor's Name)

<b>HAVE THE CIVILIAN MEDICAL BILLS BEEN PAID?</b> NO <input type="checkbox"/> YES <input type="checkbox"/>	ME <input type="checkbox"/>	ARMY <input type="checkbox"/>	CHAMPUS <input type="checkbox"/>	INSURANCE <input type="checkbox"/>	ATTORNEY <input type="checkbox"/>	OTHER <input type="checkbox"/>
(IF "Yes," please specify by whom) :			(TRICARE)			

MISCELLANEOUS INFORMATION (Required)	PLEASE SPECIFY:
Do you <i>handcarry</i> your medical record? YES <input type="checkbox"/> NO <input type="checkbox"/>	Where kept:
Are you still receiving treatment ? YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, Where:
Have you signed any release form ? YES <input type="checkbox"/> NO <input type="checkbox"/>	From Whom:
Has property damage been paid ? YES <input type="checkbox"/> NO <input type="checkbox"/>	By Whom:
Has personal injury been paid ? YES <input type="checkbox"/> NO <input type="checkbox"/>	By Whom:
Did you miss any duty days ? (*) YES <input type="checkbox"/> NO <input type="checkbox"/>	List Dates:

(\*) **NOTE:** *Active Duty* soldiers who missed complete duty days -**MUST**- submit a copy of their Leave and Earning Statement (LES) -and- complete a "CERTIFICATION STATEMENT of Military Services Due to Third Party Incident" (attached).

**ATTORNEY REPRESENTATION**

NAME OF LAW FIRM	ADDRESS
ATTORNEY'S NAME	ATTORNEY'S TELEPHONE NUMBER/FAX NUMBER
CHECK THIS BOX: IF YOU HAVE -NOT- RETAINED THE SERVICES OF AN ATTORNEY RELATIVE TO THIS INCIDENT: <input type="checkbox"/>	

**INJURED PARTY'S STATEMENT AND SIGNATURE**

**UNDER PENALTY OF PERJURY**, I CERTIFY THAT THE FORGOING INFORMATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

DATE SIGNED	INJURED PARTY'S SIGNATURE (Parent's Signature, if injured party is a minor.)
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**I HAVE ATTACHED THE BELOW-LISTED DOCUMENTS FOR REVIEW BY THE RECOVERY JUDGE ADVOCATE ATTORNEY:**

- |  |  |
|--|--|
| <input type="checkbox"/> Traffic Accident Report | <input type="checkbox"/> Leave & Earning Statement (LES) |
| <input type="checkbox"/> Auto Accident Diagram   | <input type="checkbox"/> Military Medical Record Copies  |
| <input type="checkbox"/> Insurance Policy Copy   | <input type="checkbox"/> Other Document(s)               |

**AUTHORIZATION FOR GENERAL/MEDICAL INFORMATION RELEASE**

I, \_\_\_\_\_, residing at \_\_\_\_\_  
(Full Name Printed) (Street Address)

\_\_\_\_\_, \_\_\_\_\_, having  
(City) (State and Zip Code)

received medical care at the expense of the United States of America, under the provisions of Title 32 Code of Federal Regulations, Section 220.9, and The Federal Medical Care Recovery Act (Title 42 United States Code, Sections 2651 through 2653), do hereby authorize any person assigned to or acting on behalf of the United States Army Claims Service, Office of The Judge Advocate General, Fort George G. Meade, Maryland 20755-5360, to examine, copy, or otherwise reproduce, any record, memorandum, or other document, in the possession or custody of any/or, to be informed by any physician, dentist, nurse, therapist, or any other health care provider concerning my medical history. This shall also include any present or former employer, school, Veterans Administration, Worker's Compensation Commission or Social Security Administration records. This shall also include any other person, concerning employment or school history, or any other matter relevant to economic or health background and/or health needs or conditions.

DATE: \_\_\_\_\_ SIGNED \_\_\_\_\_  
(Parent's Signature if Injured Party is a Minor)

SSN: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SPONSOR'S SSN (IF APPLICABLE): \_\_\_\_\_

NOTARY SEAL: