STATEMENT OF INCIDENT
QUESTIONNAIRE
FILLABLE FORM

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C., Section 552a)

1. **AUTHORITY:** **The Federal Medical Care Recovery Act, 42 U.S.C. 2651-3, Executive Order 9397, 10 U.S.C., Section 1095, 32 CFR, Part 220.12(I), 5 U.S.C., Section 301, 44 U.S.C., Section 3101.**
2. **PRINCIPAL PURPOSES:** **To obtain information required to enable the United States to recover the reasonable value of Government-sponsored medical care furnished at its expense from third parties.**
3. **ROUTINE USES:** **a. Identify injured party and nature of injuries. b. Identify persons involved, including witnesses and other interested parties. c. Determine the circumstances of incidents which give rise to personal injuries. d. Determine insurance coverage and source(s) of medical treatment. Information may be disclosed to civilian attorneys, insurance companies and other agencies to settle claims, and/or to the Department of Justice for use in litigation, and may be furnished to other components of the Department of Defense as required by regulation.**
4. **MANDATORY OR VOLUNTARY DISCLOSURE:** **Mandatory disclosure. Failure to provide this information will result in withholding of military medical records pertaining to medical history, diagnoses, findings, and treatment from the injured party or their representative.**

INSTRUCTIONS FOR COMPLETION
You must provide all information which pertains to the circumstances of your injury. For sections which do not apply to you, please mark "N/A" (Not Applicable) in the space provided. Attach documents supporting your statement. The regulation which requires completion of this form applies equally to active, retired, or separated United States Army personnel and/or family members.

*****RETURN COMPLETED QUESTIONNAIRE TO: *****
Mail: OFFICE OF THE STAFF JUDGE ADVOCATE, ATTN. Claims, Bldg. 1310 RM 322, Ft. Knox KY 40121
Email: usarmy.knox.usacc.mbx.sja-claims@army.mil

FAX: (502) 624-8178

INJURED PARTY INFORMATION:

NAME: _____ SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____ HOME PHONE: (_____) _____

CELL PHONE: (_____) _____ WORK PHONE: (_____) _____

EMAIL ADDRESS: _____

PRESENT ADDRESS: _____
Bldg, /Apt # **Street Name** **City** **State** **Zip**

BRANCH OF SERVICE: ____ARMY ____NAVY ____AIR FORCE ____COAST GUARD ____USPHS ____NOAA

STATUS: ____ Active Duty ____ Retired ____Dependent ____ Civilian (non-military affiliation)

BASIC ACTIVE SERVICE DATE (BASD): _____ EXPERATION TERM OF SERVICE (ETS): _____

SPONSOR: NAME_____ RANK: _____ SSN: _____

DATES YOU WERE UNABLE TO PERFORM MILITARY DUTIES, IF APPLICABLE:

FROM: _____TO:_____

Please provide a copy of your conversant leave and/or sick leave slip.

ACTIVE DUTY: ORGANIZATION & ADDRESS: _____

_____

(Include Bldg, Street Name, City, State, Zip, Telephone #)

ACCIDENT DATE: _____**DESCRIBE INJURIES**: _____

LOCATION: _____

Bldg Street City County State Zip

NAME OF POLICE AGENCY THAT INVESTIGATED: _____

PLEASE ATTACH A COPY OF THE POLICE OR INCIDENT REPORT. CASE#: _____

HOW INJURED: ____ Driver ____ Passenger ____ Pedestrian _____ Assault ____ Dog Bite

____Slip/Fall ____ On the Job Injury ____ Medical Mal-Practice

Specify if other: _____

ARE YOU STILL RECEIVING TREAMENT FOR YOUR INJURIES: _____

LAST DATE OF TREATMENT: _____

IF YOU HIRED AN ATTORNEY, PLEASES PROVIDE:

NAME: _____

ADDRESS: _____

_____PHONE NUMBER (_____) _____

FAX NUMBER: (_____) _____ EMAIL ADDRESS: _____

FOR VEHICLE ACCIDENTS, COMPLETE THE FOLLOWING:
FOR NON-VEHICLE INCIDENTS, SEE PAGE 4

YOUR AUTO INSURANCE for this incident: _____ PHONE: (_____) _____

INSURANCE ADDRESS: _____

POLICY NUMBER: _____CLAIM NUMBER: _____

MAKE/MODEL: _____

NAME OF DRIVER/OWNER OF VEHICLE THAT STRUCK YOU: _____

VEHICLE'S OWNER INSURANCE & PHONE #:_____

INSURANCE ADDRESS: _____

POLICY NUMBER: _____**CLAIM NUMBER**: _____

If you were DRIVING a car BELONGING TO SOMEONE ELSE OR a PASSENGER, please complete the following:

DRIVER _____OWNER _____

ADDRESS OF OWNER: _____

_____ PHONE NUMBER: (_____) _____

VEHICLE OWNER'S INSURANCE & PHONE # (day of accident) _____

INSURANCE ADDRESS: _____

POLICY NUMBER: _____**CLAIM NUMBER**: _____

Please draw a diagram to show what happened. Label your vehicle as number one (1), other vehicles as number two (2), three (3), etc. (use the back page or add a continuation sheet if necessary). **CONTINUE** with "**FOR ALL INCIDENTS**".

IF THIS WAS A NON-AUTO INCIDENT:

Place of Injury: ____ Employment ____ Business ____ Municipality ____ Homeowner ____ Other (specify)

If other: _____

_____
Name and telephone number of home/business owner, manager, etc.:

_____
Name and telephone number of insurance company of home/business owner, manager, etc.:

_____
(Insurance company mailing address) Bldg # or P.O. Box # **Street Name**

_____
City **State** **Zip Code**

POLICY NUMBER: _____**CLAIM NUMBER**: _____

FOR ALL INCIDENTS:
Please summarize the facts of the incident: (use the back page or add a continuation sheet if necessary)

_____

_____

_____

_____

_____

I have completed the above questionnaire as fully and as accurately as possible.

Signature: _____ **Date:** _____
(Injured party **or** representative **or** law office) **(Please attach Police Report)**