Workers' Compensation Board
Alberta

P.O. BOX 2415
EDMONTON AB
T5J 2S5

AUTOMOBILE ACCIDENT REPORT

Claim Number

Worker's *Surname*	*First Name*	*Initial*	Date of Birth *(Year / Month / Day)*
Home Address *Street*	*City/Town*	*Province*	Postal Code
Telephone Number ( ) –	Your Insurance Company and Policy Number		
Business Address *Street*	*City/Town*	*Province*	Postal Code
Telephone Number ( ) –			

Make of Vehicle	Year	Model	Serial Number	License Number and Province
Describe Damage				
				Estimate of Damage

Name of Driver of Your Vehicle	Age	Driver's License Number	
Residence Address *Street*	*City/Town*	*Province*	Postal Code
Business Telephone Number: ( ) –			

Date of Accident *(Year / Month / Day)*	Time ☐ A.M. ☐ P.M.	Were you wearing a seat belt? ☐ Yes ☐ No	
Location of Accident			
Purpose vehicle used for at time of accident		Weather Condition	Road Condition
Your Speed	Direction	Other's Speed	Direction
Police Investigation by			Charges
Had you taken any alcoholic beverages or drugs prior to the accident ☐ Yes ☐ No			
Who was responsible for the accident – reason			

Owner of other vehicle		Owner of other vehicle	
Telephone Number ( ) –		Telephone Number ( ) –	
Address		Address	
Make of Vehicle	Year	Make of Vehicle	Year
Model	License Number and Province	Model	License Number and Province
Name of Insurance Company	Policy number	Name of Insurance Company	Policy number
Description of Damage		Description of Damage	
Name of Driver	Telephone Number ( ) –	Name of Driver	Telephone Number ( ) –
Address		Address	

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Complete both pages and sign before sending.

Worker's *Surname*	*First Name*	*Initial*	Claim Number

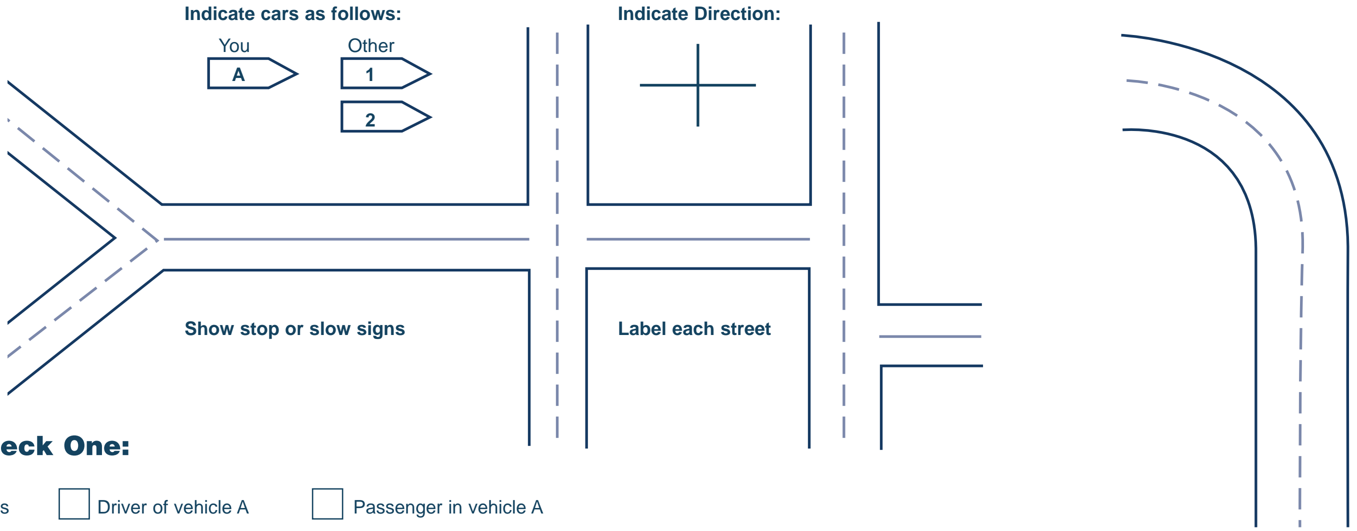
Details of Accident

Witnesses

Name	Name	Name
Address	Address	Address
Telephone Number ( ) –	Telephone Number ( ) –	Telephone Number ( ) –
In which Car? ☐ Your Car ☐ Other Car #1 ☐ Other Car #2 ☐ Other	In which Car? ☐ Your Car ☐ Other Car #1 ☐ Other Car #2 ☐ Other	In which Car? ☐ Your Car ☐ Other Car #1 ☐ Other Car #2 ☐ Other

Description of Accident

Illustrate position of cars at time of collision. Show skid marks.
(If any street is more than two lanes or is one way only, please indicate.)



Check One:

I was ☐ Driver of vehicle A ☐ Passenger in vehicle A

Describe the accident in your own words (attach separate sheets if necessary.)

(Year / Month / Day)

Date ______ Signature ______

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