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**MOTOR ACCIDENT INSTRUCTIONS SHEET**

**NAME OF CASE**

Client's name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

P.P.S. No. \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_

Are you registered for VAT \_\_\_\_\_

**DETAILS OF ACCIDENT**

Date of Accident: \_\_\_\_\_

Time of Accident: \_\_\_\_\_

Location: \_\_\_\_\_

Your Car Registration No. \_\_\_\_\_

Your Insurance Company: \_\_\_\_\_

Your Policy No. \_\_\_\_\_

Type of Policy:  
(3rd Party Fire & Theft  
Comprehensive) \_\_\_\_\_

Was seat belt worn by you: \_\_\_\_\_

Were you a passenger (if so  
state front or back seat): \_\_\_\_\_

In the 24 hour period before the  
accident had you consumed: -  
(a) Alcohol \_\_\_\_\_

(b) Drugs \_\_\_\_\_

(c) Medication \_\_\_\_\_

**3RD PARTY DETAILS/OTHER DRIVERS**

Name of 3rd Party (Other Driver) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Name of Owner of other car: \_\_\_\_\_

Address of Owner: \_\_\_\_\_  
\_\_\_\_\_

Registration No. of car: \_\_\_\_\_

**3RD PARTY/OTHER DRIVER  
INSURANCE COMPANY**

Policy No. \_\_\_\_\_

Insurance Company: \_\_\_\_\_

**FAULT:**

**DID 3RD PARTY/OTHER DRIVER  
ADMIT FAULT**

(a) **VERBALLY** \_\_\_\_\_

(b) **IN FRONT OF  
A WITNESS** \_\_\_\_\_

(c) **IN WRITING** \_\_\_\_\_

**GARDAI**

Where they called? \_\_\_\_\_

If so: -  
Names: \_\_\_\_\_

Station: \_\_\_\_\_

If not called did you report  
accident if so to whom? \_\_\_\_\_

**HOSPITAL**

Did you attend or have you been sent by your GP? \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Doctor/Consultant: \_\_\_\_\_

Duration of stay: \_\_\_\_\_

Injuries: \_\_\_\_\_  
\_\_\_\_\_

Treatment received: \_\_\_\_\_

Next visit due: \_\_\_\_\_

**GP**

GP's name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Have you attended your GP in relation to this accident: \_\_\_\_\_

Treatment from GP \_\_\_\_\_

**PHYSIOTHERAPY/OTHER TREATMENT**

Have you attended for such treatment or have you been advised to? \_\_\_\_\_

If so by whom? \_\_\_\_\_

**WITNESS DETAILS**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**EMPLOYMENT DETAILS**

Name of Employer: \_\_\_\_\_

Address of Company: \_\_\_\_\_

\_\_\_\_\_

Have you missed time from work? \_\_\_\_\_

Gross Earnings: € \_\_\_\_\_

Net Earnings: € \_\_\_\_\_

Total Loss of Earnings: € \_\_\_\_\_

Social Welfare Payments received if any € \_\_\_\_\_

Social Welfare Number \_\_\_\_\_

Are you entitled to a Medical Card? \_\_\_\_\_

**EXPENSES**

Travelling: \_\_\_\_\_

Damage to your motor car: (give estimate or receipt) \_\_\_\_\_

Damage to clothes: \_\_\_\_\_

Medicines: \_\_\_\_\_

\_\_\_\_\_

GP's Fees: \_\_\_\_\_

Consultants fees \_\_\_\_\_

Hospital fees \_\_\_\_\_

Physiotherapy fees \_\_\_\_\_

Miscellaneous: \_\_\_\_\_

**HOW ACCIDENT OCCURRED**

Give a short account describing accident: -

**MAP OF SCENE OF ACCIDENT**

**PREVIOUS ACCIDENTS**

Were you involved in any previous accidents?

If so furnish: -

1. Dates of previous accidents: \_\_\_\_\_
2. Injuries sustained: \_\_\_\_\_
3. Details of compensation received if any: \_\_\_\_\_
4. Name of Solicitor engaged by you: \_\_\_\_\_

**PREVIOUS MEDICAL HISTORY**

Have you suffered from any illness, medical complaint or disability in the past?

\_\_\_\_\_

If so give full details

\_\_\_\_\_

\_\_\_\_\_

I confirm that the information is true and accurate, and instruct John L. Mulvey & Co., Solicitors to act on my behalf in relation to this matter

Dated this    day of                          201\_

Signed: \_\_\_\_\_