

**AUTO COLLISION CLIENT STATEMENT CHECKLIST:**

YOUR FULL NAME:

ADDRESS

TELEPHONE NUMBER

DEFENDANT'S FULL NAME

ADDRESS

TELEPHONE NUMBER

WHAT WAS DATE OF EVENT

WHERE DID COLLISION OCCUR:

DESCRIBE WHAT HAPPENED:

DID THE POLICE COME AND MAKE A REPORT?

IF THERE WERE WITNESSES, WHAT ARE THEIR NAMES  
AND ADDRESSES?

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DESCRIBE THE DAMAGE TO ALL THE VEHICLES:

WHAT IS THE NAME OF YOUR DOCTOR

WHERE WERE YOU HURT

PLEASE DESCRIBE YOUR TREATMENT IN DETAIL

HOW MUCH ARE YOUR MEDICAL BILLS?

DO YOU HAVE INSURANCE? Y/N

WHAT KIND OF INSURANCE

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