

Please return completed form to:

Sender:

Universität Paderborn
Personaldezernat
Warburger Str. 100
33098 Paderborn, Germany

Commuting Accident: Questionnaire

Please submit this questionnaire together with the accident report.

Questions	Answers
1 Time and location of the accident	
1.1 When did the accident occur?	Date: _____ Time: _____
1.2 Your working hours on the day of the accident?	Start: _____ (time) End: _____ (time)
1.3 Did the accident occur during a work break?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer question 1 on the supplemental sheet.
1.4 Where did the accident occur (exact location and street/road name and details)?	
1.5 At what place (road, pavement, inside or outside your house, etc.)?	
2 Starting point and destination of the commute route	
2.1 Where were you coming from when the accident happened (e.g. place of work or home, please include exact address)?	
2.2 Where were you planning to go (exact address)?	
2.3 What time did you start on the route where the accident occurred?	If the accident occurred on the way to the workplace: Left your home at _____ (time) Start of workday on the date of the accident _____ (time) If the accident occurred on the way from the workplace: Left the workplace at _____ (time) Actual end of workday on the date of the accident _____ (time)

Questions		Answers		
2.4	Which route do you usually take from your home to the workplace and vice versa? (Please specify exact location and street/road name and details.)			
2.5	How do you usually travel (e.g. walking, car, bus, train, etc.)?			
2.6	How long is the usual route?	kilometres		
2.7	How much time does the route take?	hour(s)	minute(s)	
2.8	Is this the direct route between your home and workplace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
		If no, why don't you take the direct route?		
2.9	Which route did you take when the accident occurred (exact location and street/road name and details)?			
2.10	If you did not take the usual route:			
2.10.1	Why did you take a different route?			
2.10.2	How did you travel (walking or what means of transportation)?			
2.10.3	How much longer/more time-consuming is this route than the usual route?	kilometres/	hour(s)	minute(s)
2.11	Did you complete or plan to complete any errands or make any visits or any other stops along the way (e.g. shopping, doctor's appointment, stop at a restaurant, administrative errands)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
		If yes, please answer question 2 on the supplemental sheet.		

Please enclose a copy of a website printout (route planner) or map of the route to the completed questionnaire. In particular, please indicate the starting point (**S**), destination (**D**) and location of the accident (**L**) and, if applicable, your home (**H**) and place of work (**W**) – if these locations differ from one other.

Please mark the direct route between your home and workplace with a dashed line (- - -) and mark the route taken on the day of the accident with a solid line (-----).

- This facilitates our insurance-related investigation pursuant to insurance law - -

3 Circumstances of accident and injuries

3.1	How did the accident happen?			
3.2	Who accompanied you (name, address)?			
3.3	Was there an eyewitness to the accident (name, address)?			

Questions	Answers
3.4 Who was the first person to approach the accident scene (name, address)?	
3.5 Who performed first aid (name, address)?	
3.6 What doctor/hospital did you visit after the accident (name, address)? When (date, time)?	
3.7 What discomfort/medical problems/consequences of the accident did you notice?	
3.8 Did you (continue to) work after the accident? If yes, until when (date and time)?	<input type="checkbox"/> No <input type="checkbox"/> Yes, from _____ to _____ (time)
3.9 Have you returned to work? If yes, when?	<input type="checkbox"/> No <input type="checkbox"/> Yes, on _____ at _____ (time)
3.10 What doctors (please provide exact addresses) did you visit in connection with the abovementioned accident?	
3.11 Are you currently still undergoing medical treatment due to the consequences of the abovementioned accident? If yes, under which doctor's care?	
3.12 a) What health insurance companies have you been insured with over the past 10 years (please provide the names, exact addresses and membership numbers)? b) First name, surname and date of birth of the primary insured person?	
3.13 Have any findings been determined or issued by the police or others (e.g. by the public prosecutor's office, insurance company)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom (name, address, file/reference number)?

4 Persons involved in the accident

4.1 Was another vehicle involved in the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer question 3 on the supplemental sheet.
4.2 Is the accident attributed to winter road conditions, damaged roads, building defects, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer question 4 on the supplemental sheet.
4.3 Was another person or an animal involved in the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer question 5 on the supplemental sheet.

City, date

Signature

Telephone number for enquiries

**Supplemental Sheet
to Commuting Accident Questionnaire**

Please only answer the required questions! –

Questions	Answers
1 The accident occurred during a work break.	
1.1 How long was your work break?	From (time) to (time)
1.2 Why did you leave the workplace (for what purpose)?	
1.3 Where did you want to go during the work break?	
1.4 How far is that location from the workplace?	kilometres/ hour(s) minute(s)
2 If you did errands, made visits, etc. along the way.	
2.1 Which and where (exact name and address)?	
2.2 For what reason?	
2.3 How long were you there or would you have been there?	From (time) to (time)
2.4 Did the accident happen before, during or after the errand, visit, etc.?	<input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> After
2.5 Did you consume any alcohol or alcoholic beverages prior to the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If so, what kind and how much?

Questions		Answers	
3 Other vehicles were involved in the accident.			
		(1st) vehicle	(2nd) vehicle
3.1	Type of vehicle(s)		
3.2	Licence plate number / registration number / nationality		
3.3	Have any attorneys been brought in?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Please provide name and address.	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Please provide name and address.
4 The accident was attributed to winter road conditions, damaged roads, building defects, etc.			
4.1	What, specifically?		
4.2	In your opinion, who is responsible for maintaining safety (e.g. duty to grit the pavement/road) at the scene of the accident (name, address)?		
5 Another person or an animal was involved in the accident.			
5.1	How? What were the circumstances?		
5.2	What is the name and address of the person or owner of the animal?		
5.3	What insurance company is the other party insured with (name and address of the insurance company, insurance policy number)?		