1 - LOSS AND DAMAGE { MERGEFIELD MATTER_FEE_EARNER_ID }/{ MERGEFIELD client_no }/{ MERGEFIELD matter_no }	
1.1 LOSS OF EARNINGS **Did you lose earnings as a result of the accident? Y / N** **If no, please go to 1.2.** **If yes, please answer (a) below if you were employed at the time of accident; (b) below if you were self-employed at the time of the accident; and (c) below if you were unemployed at the time of the accident.** **Where a claim is made for lost earnings please provide copies of payslips for a period of 13 weeks prior to the accident or provide copies of business records, accounts and tax returns for the last few years if self-employed**	
(a) Employed Before Accident	
EMPLOYER'S NAME:	EMPLOYEE NUMBER:
EMPLOYERS'S ADDRESS:	
JOB TITLE:	JOB DESCRIPTION:
AVERAGE GROSS SALARY:	
AVERAGE NET SALARY (after deductions for tax, National Insurance etc):	
PAID: daily/weekly/monthly/other (please specify)	
BONUSES: Y / N	HOLIDAY PAY: Y / N
OVERTIME: Y / N	PERFORMANCE RELATED PAY: Y / N

OTHER REWARDS e.g. lunch vouchers, free petrol and private healthcare:	
DATE COMMENCED WORK:	
TIME OFF WORK TO DATE:	DATE RETURNED TO WORK:
MISSED PROMOTIONAL OPPORTUNITIES (IF ANY):	
BENEFITS RECEIVED TO DATE:	
(b) Self-Employed Before Accident	
NAME OF BUSINESS:	
TYPE OF BUSINESS:	
PAYMENT: cash in hand/cheques/BACS/Other please specify	
GROSS PROFIT IN LAST TAX YEAR:	
NET PROFIT IN LAST TAX YEAR (after deductions for expenses, tax, National Insurance etc):	
TIME OFF WORK TO DATE:	DATE RETURNED TO WORK:
MISSED OPPORTUNITIES/LOSS OF GOODWILL:	
NAME AND ADDRESS OF ACCOUNTANT:	
(c) Unemployed Before Accident	
PRE-ACCIDENT VOCATION (IF ANY):	
QUALIFICATIONS, TRAINING AND EXPERIENCE:	
EMPLOYMENT HISTORY (INCLUDING DATES):	

NAMES AND ADDRESSES OF PREVIOUS EMPLOYERS:

LENGTH OF TIME OUT OF WORK PRIOR TO ACCIDENT:

DETAILS OF ANY JOB OFFERS OR OPPORTUNTIES RECEIVED PRIOR TO ACCIDENT:

1.2 PENSION LOSS
If you have a company or private pension and by reason of the accident you have been unable to make pension contributions, please complete the section below. If not, please go to 1.3.

COMPANY PENSION: Y / N	PERSONAL PENSION: Y / N
POLICY No:	WAIVER OF PREMIUM BENEFIT: Y / N

DETAILS OF PENSION PROVIDER:

COPY OF PENSION SCHEME TRUST DEED ENCLOSED: Y / N

COPY OF PENSION POLICY BOOKLET/RULES ENCLOSED: Y / N

INTENDED RETIREMENT AGE: 50/55/60/65/Other (please specify)

1.3 CLOTHING

(a) Clothing Destroyed, Damaged by the Accident (Including Shoes, Books & Protective Clothing)
eg jacket ripped in accident bought 2 years ago for £ 100 value at time of accident £50

ITEM	NATURE OF DAMAGE	AGE	COST NEW	APPROX VALUE AT TIME OF ACCIDENT

(b) Clothing Bought as a Result of the Accident (Including Shoes, Boots & Protective Clothing)
eg larger shoes and socks to fit over plaster cast

DATE BOUGHT	ITEM	REASON BOUGHT	COST	RECEIPT ENCLOSED

1.4 POSSESSIONS

e.g. damaged jewellery

ITEM	NATURE OF DAMAGE	AGE	COST NEW	APPROX VALUE AT TIME OF ACCIDENT

1.5 MEDICAL EXPENSES

(a) Medical Treatment

e.g. private hospital and dental treatment as well as physiotherapy, osteopathy, chiropractic treatment, acupuncture etc

DATE	ITEM	COST	RECEIPT ENCLOSED: Y/N	COMMENT

ARE YOUR MEDICAL/DENTAL EXPENSES COVERED BY MEDICAL INSURANCE:
Y / N IF SO, PLEASE GIVE THE FOLLOWING DETAILS:

MEDICAL INSURER:	ADDRESS:	POLICY NUMBER:
DENTAL INSURER:	ADDRESS:	POLICY NUMBER:

(b) Prescriptions and Medication

e.g. painkillers, sleeping tablets, anti-depressants, gels, creams and lotions

DATE	ITEM	COST	RECEIPT ENCLOSED: Y/N	COMMENT

(c) Other

e.g. supports, bandages and plasters etc

DATE	ITEM	COST	RECEIPT ENCLOSED: Y/N	COMMENT

1.6 TRAVEL

Please include all costs incurred travelling to and from hospital, physiotherapy appointments, legal visits and experts

(a) Public Transport

e.g. bus, tube and train etc

DATE	DESTINATION	MODE OF TRANSPORT	COST	RECEIPT ENCLOSED: Y/N

(b) Travel by Car/Motorcycle

DATE	DESTINATION	VEHICLE	ROUND TRIP MILEAGE	PARKING AND OTHER FEES

(c) Other

e.g. taxi fares, plane tickets etc

DATE	DESTINATION	MODE OF TRANSPORT	COST	RECEIPT ENCLOSED: Y/N

1.7 CARE AND ASSISTANCE

If you have required any assistance with washing, dressing, cooking, cleaning or driving please complete the following section. If not, go to 1.8.

(a) Professional Care

e.g. nurse, home help or cleaner

DATE	NAME OF CARER	TYPE OF CARE PROVIDED	TIME SPENT (IN HOURS)	COST (PER HOUR)

IS THE NEED FOR CARE CONTINUING? Y / N

(b) Friends & Family

DATE	NAME OF CARER	TYPE OF CARE PROVIDED	TIME SPENT (IN HOURS)	ANY LOST EARNINGS

IS THE NEED FOR CARE CONTINUING? Y / N

(c) Visits to hospital

Please complete this section if any friends or relatives incurred expenses visiting you in hospital

DATE	NAME OF VISITOR	EXPENSES	RECEIPT ENCLOSED: Y/N	COMMENT

1.8 AIDS & EQUIPMENT

Please complete this section if, as a result of the accident, you have had to buy any items to assist with daily life, eg a wheelchair, an orthopaedic pillow, a commode, a walking stick etc. If not, please go to 1.9 below

ITEM	DATE BOUGHT	COST	RECEIPT ENCLOSED: Y/N	COMMENT

1.9 ACCOMODATION
Please complete this section if you have had any difficulty with your present accommodation by reason of your injury. If not, go to 1.10.

IS YOUR PRESENT ACCOMMODATION SUITABLE FOR YOUR NEEDS? Y / N
IF NO, PLEASE STATE THE REASONS WHY IT IS UNSUITABLE:

HAVE YOU CARRIED OUT ANY ADAPTATIONS TO YOUR HOME AS A RESULT OF THE ACCIDENT? Y / N
IF YES, PLEASE DETAIL BELOW

DATE	ADAPTATION	COST	RECEIPT ENCLOSED: Y/N	COMMENT

1.10 DIY/DECORATING/CAR MAINTENANCE/GARDENING

(a) DIY and Decorating

PRIOR TO THE ACCIDENT DID YOU DO ANY MAINTENANCE, REPAIR OR DECORATION WORK AROUND YOUR HOUSE? Y / N

HAVE YOU HAD TO PAY ANYONE TO CARRY OUT ANY DIY OR DECORATING THAT, BUT FOR YOUR INJURIES, YOU WOULD HAVE DONE YOURSELF? Y / N

IF YES, PLEASE DETAIL THE FOLLOWING MAKING SURE THAT ALL COSTS ARE FOR *LABOUR* COSTS ONLY

DATE	WORK DONE	COST	RECEIPT ENCLOSED: Y/N	COMMENT

DO YOU HAVE ANY OUTSTANDING JOBS THAT NEED TO BE DONE THAT, BUT FOR YOUR INJURIES, YOU WOULD HAVE DONE YOURSELF? Y / N

IF YES, PLEASE PROVIDE THE FOLLOWING DETAILS

WORK TO BE DONE	DATE TO BE COMPLETED	ESTIMATED COST	ESTIMATE ENCLOSED: Y/N	COMMENT

DO YOU HAVE A CONTINUING NEED FOR ASSISTANCE WITH DIY AND DECORATING? Y/N

(b) Vehicle Maintenance

DID YOU UNDERTAKE YOUR OWN VEHICLE MAINTENANCE PRIOR TO THE ACCIDENT? Y / N

IF YES, BY REASON OF YOUR INJURIES, HAVE YOU BEEN PROHIBITED FROM UNDERTAKING THIS WORK? Y / N

IF YES, HAVE YOU PAID ANYONE TO DO REPAIR OR MAINTENANCE WORK THAT, BUT FOR YOUR INJURIES, YOU WOULD HAVE DONE YOURSELF? Y/N

IF YES, PLEASE PROVIDE DETAILS BELOW

DATE	VEHICLE	WORK	COST	COMMENT

DO YOU HAVE ANY CONTINUING NEED FOR ASSISTANCE WITH VEHICLE MAINTENANCE? Y/N

(c) Gardening

DO YOU HAVE A GARDEN? Y / N

IF YES, PRIOR TO THE ACCIDENT, DID YOU TEND TO THE GARDEN YOURSELF? Y/N

IF YES, BY REASON OF YOUR INJURIES, HAVE YOU HAD TO PAY ANYONE TO TEND TO YOUR GARDEN? Y/N

IF YES, PLEASE COMPLETE THE FOLLOWING DETAILS

DATE	WORK DONE	COST	RECEIPT ENCLOSED: Y/N	COMMENT

DO YOU HAVE A CONTINUING NEED FOR ASSISTANCE WITH YOUR GARDEN? Y / N

1.11 SPECIAL ITEMS OF EXPENDITURE
Please set out any 'one-off' or special items of expenditure such as a new car, a special diet or a mobile phone. If you have no such expenses, please go to1.12

DATE	ITEM	COST	RECEIPT ENCLOSED: Y / N	COMMENT

1.12 DEBTS OR CHARGES
Have you incurred any debts or charges as a result of the accident such as overdraft interest or interest on loans:
Y / N
If yes, please detail below. If not, please go to 4.13 below.

4.12 DEBTS OR CHARGES
Have you incurred any debts or charges as a result of the accident such as overdraft interest or interest on loan: Y / N
If yes, please detail below. If not, please go to 4.13 below.

DATE	AMOUNT	CREDITOR	RECEIPT ENCLOSED: Y / N	COMMENT

1.13 MISCELLANEOUS

(a) Incidental Expenses

PLEASE ESTIMATE THE AMOUNT YOU HAVE SPENT TO DATE ON POSTAGE, TELEPHONE CALLS, STATIONERY, FAXES AND PHOTOCOPYING PURSUING YOUR CLAIM:

(b) Photographic charges

DATE	SUBJECT OF PICTURES	COST	RECEIPT ENCLOSED: Y/N	COMMENT

(c) Other

Please give details of any other items of loss or expenses not covered above

DATE	ITEM	COST	RECEIPT ENCLOSED: Y/N	COMMENT

2 - **CONSENT FORMS AND DECLARATION**

2.1 - GENERAL PRACTIONER RECORDS

I HEREBY AUTHORISE THE RELEASE OF ALL GENERAL PRACTIONER RECORDS TO **{** MERGEFIELD PRACTICEINFO_PRACTICE_NAME *Upper **}**, **{** MERGEFIELD client_no **}**, **{** MERGEFIELD PRACTICEINFO_HOUSE *Upper **}**, **{** MERGEFIELD PRACTICEINFO_AREA *Upper **}**, **{** MERGEFIELD PRACTICEINFO_POSTAL_TOWN *Upper **}**, **{** MERGEFIELD PRACTICEINFO_POSTCODE *Upper **}** CONFIRM THAT THE RECORDS ARE SOUGHT IN RELATION TO CLAIM FOR PERSONAL INJURY ARISING OUT OF AN ACCIDENT AND THAT NO ACTION IS INTENDED AGAINST MY GENERAL PRACTITIONER.	
SIGNED:	DATED:
2.2 HOSPITAL RECORDS	
I HEREBY AUTHORISE THE RELEASE OF ALL MY HOSPITAL RECORDS TO **{** MERGEFIELD PRACTICEINFO_PRACTICE_NAME *Upper **}**, **{** MERGEFIELD client_no **}**, **{** MERGEFIELD PRACTICEINFO_HOUSE *Upper **}**, **{** MERGEFIELD PRACTICEINFO_AREA *Upper **}**, **{** MERGEFIELD PRACTICEINFO_POSTAL_TOWN *Upper **}**, **{** MERGEFIELD PRACTICEINFO_POSTCODE *Upper **}**. I CONFIRM THAT THE RECORDS ARE SOUGHT IN RELATION TO A CLAIM FOR PERSONAL INJURY ARISING OUT OF AN ACCIDENT AND THAT NO ACTION IS INTENDED AGAINST THE NHS TRUST OR HEALTH AUTHORITY.	
SIGNED:	DATED:
2.3 DECLARATION	
I BELIEVE THE FACTS STATED IN THE ABOVE QUESTIONNAIRE ARE TRUE	
SIGNED:	DATED:

NOTES

1. If any section or question is not relevant to you, please leave it blank, cross it through or write 'N/A'.
2. In order to be claimable any financial loss must be reasonably incurred as a result of the accident: losses which would have occurred in any event are not claimable.
3. Please keep a record of all expenditure that has been incurred as a result of the accident.
4. It is very important that you keep copies of all receipts and invoices in respect of any losses or expenses incurred as a result of the accident.
5. Where a claim is made for lost earnings please provide copies of payslips for a period **of** 13 weeks prior to the accident or provide copies of business records, accounts and **tax** returns for the last few years if self-employed.
6. Please obtain estimates for items or services that you wish to benefit from in the future.