



Name of Nominee	Age at Time of Crash	Date of Birth
Address		County of Residence
City	State	Zip
Home telephone	E-mail Address	
Date of crash		
Time of the crash		
Location of the crash (county and city)		
Type of vehicle the nominee was in (year, make and model)	Was the nominee a: <input type="checkbox"/> driver <input type="checkbox"/> passenger	
Briefly describe the crash. How did it happen?		

Was anyone hurt in the crash? If so, please describe the injuries. ☐

Briefly describe the damage to the vehicle and other vehicles if involved.

Agency Name	
Name of Law Enforcement Officer/Emergency Service Responder	
Address	Phone
E-mail Address	Date

Submit this form by mail or fax to: NYSDOH Bureau of Injury Prevention  
Riverview Center 150- Broadway, Suite 302  
Albany, NY 12204-0677  
518-473-1143(p) 518-474-3067(f)  
E-mail: [injury@health.state.ny.us](mailto:injury@health.state.ny.us)