OMB Control Number: 2127-0706
Expiration Date: 08/31/2025

CRASH INVESTIGATION SAMPLING SYSTEM

# Non-Motorist Interview Form

**PSU Number** ___ ___

**Case Number** __ ___ __N M _

**Non-Motorist Number** __

**Interviewee(s) Role or Name(s):**

_____

_____

**Phone Number:** (____) _____

| Non-Motorist # | Name | Date of Birth | Medical Facility *(If multiple treatment locations – list all)* | Discharge Date(s) |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

**Date, Time, and Place to have medical release signed:**

**Other identifying information:**

OMB Control Number: 2127-0706
Expiration Date: 08/31/2025

U.S. Department of Transportation
National Highway Traffic Safety
Administration

# NON-MOTORIST INTERVIEW

CRASH INVESTIGATION SAMPLING SYSTEM

**Primary Sampling Unit Number** _____

**Case Number** _____

**Non-Motorist Number** _____

These reports are authorized by P.L. 89-563, Title 1, Section 106, 108, and 112. While you are not required to respond, your cooperation is needed to make the results of this data collection effort comprehensive, accurate, and timely.

| Pre-Impact Striking Vehicle Information | |
|---|---|
| **1. Can you describe how the vehicle approached you before the impact?** | (text) |
| **2. From which direction did the striking vehicle approach you?**<br><br>*(Relative to pedestrian's stance)* | □ Front<br>□ Left<br>□ Right<br>□ Back<br>□ Unknown |
| **3. Were there other vehicles approaching you? If so, from which direction?**<br><br>*Select all that apply.* | □ No<br>□ Yes, same direction as striking vehicle<br>□ Yes, opposite direction as striking vehicle<br>□ Yes, perpendicular to striking vehicle<br>□ Unknown |
| **4. Did you hear the vehicle approaching?** | □ Yes<br>□ No<br>□ Unknown |
| **5. Did you see the vehicle that struck you before the impact?**<br><br>*If "No" or "Unknown" skip questions 5a and 5b.* | □ Yes<br>□ No<br>□ Unknown |
| **5a. Can you estimate (distance, time, or qualitative) how far away the vehicle was when you first saw it?** | (text) |
| **5b. Did you see the vehicle accelerate, brake, or steer prior to the collision?**<br><br>*Select all that apply.* | □ Accelerate<br>□ Brake<br>□ Steer left<br>□ Steer right<br>□ Other, specify_____<br>□ None<br>□ Unknown |

| Pre-Impact Pedestrian Information | |
|---|---|
| **6. What do you remember about what you were doing just prior to being struck?**<br><br>*If no recollection skip questions 7-10* | (text) |
| **7. Just prior to the impact, were you: (attitude)** | □ Standing, walking, or running<br>□ Crouching or kneeling<br>□ Bending at waist<br>□ Riding<br>□ Other, specify _____<br>□ Unknown |
| **8. Just prior to the impact, were you: (motion)** | □ Stopped<br>□ Walking<br>□ Walking rapidly<br>□ Running or jogging<br>□ Jumping<br>□ Falling or rising<br>□ Riding<br>□ Other, specify _____<br>□ Unknown |
| **9. Just prior to the impact, were you: (road crossing)** | □ Crossing road straight<br>□ Crossing road diagonally<br>□ Moving in road with traffic<br>□ Moving in road against traffic<br>□ Off road approaching road<br>□ Off road going away from road<br>□ Off road crossing driveway<br>□ Off road moving along driveway<br>□ Other, specify _____<br>□ Unknown |
| **10. Relative to the vehicle, what direction was your motion?** | □ Stopped<br>□ Toward vehicle<br>□ Away from vehicle<br>□ Left-to-right in front of vehicle<br>□ Right-to-left in front of vehicle<br>□ Other, specify _____<br>□ Unknown |
| **11. Were you pushing, pulling, or carrying a large object? Like a cart, stroller, bicycle, umbrella, shopping bag, or luggage?** | □ No<br>□ Pushing, specify: _____<br>□ Pulling, specify: _____<br>□ Carrying, specify: _____ |
| **12. Were you moving (walking/jogging, riding) alone, with someone else, or in a group?** | □ Alone<br>□ With others, specify how many: ____<br>□ Unknown |

| Pedestrian Vision | |
|---|---|
| **13. Where were you looking just before the impact?** | □ At vehicle<br>□ Away from vehicle<br>□ At intended path<br>□ At another vehicle or object<br>□ Other, specify _____<br>□ Unknown |
| **14. Did anything obstruct your view of the approaching vehicle?**<br><br>*Select all that apply.* | □ No<br>□ Other moving vehicle<br>□ Parked (or stationary) vehicle<br>□ Tree/shrubbery/foliage<br>□ Permanent Object, Specify _____<br>□ Dark/Low lighting<br>□ Glare<br>□ Other, Specify _____<br>□ Unknown |
| **15. Did any environmental factor affect your vision such as sun glare, rain/snow, or wind?** | □ No<br>□ Sun glare<br>□ Rain/Snow<br>□ Wind<br>□ Other, specify: _____ |
| **16. Were you using a cell phone at the time of the crash?**<br><br>*Select all that apply.* | □ No<br>□ Talking on the phone<br>□ Reading/answering a text message<br>□ Viewing the screen<br>□ Listening music/podcast on headphones |
| **17. Did you have alcohol or another drug (over-the-counter, prescription, or other) within 12 hours of the crash?**<br><br>*If "No" or "Refused" skip question 17a.* | □ Yes<br>□ No<br>□ Refused |
| **17a. Did you feel impaired by any substance?**<br><br>*Select all that apply* | □ No<br>□ Alcohol<br>□ Prescription Drugs, specify _____<br>□ Other, specify _____ |

| Pedestrian Avoidance and Positioning at Impact | |
|---|---|
| **18. What do you remember about the moment the vehicle stuck you?**<br><br>*If no recollection skip questions 19 to 26.* | (text) |
| **19. Did you do anything to avoid being hit, like:**<br><br>*Select all that apply.*<br><br>*If "No" or "Unknown" skip 19a and 19b.* | □ Stopping<br>□ Accelerating pace<br>□ Changing direction<br>□ Jumping<br>□ Turning toward vehicle<br>□ Turning away from vehicle<br>□ Diving or falling down<br>□ Other, specify _____<br>□ Unknown |
| **19a. If so, which direction did you move?** | □ Toward vehicle<br>□ Away from vehicle<br>□ Left-to-right in front of vehicle<br>□ Right-to-left in front of vehicle<br>□ Other, specify _____<br>□ Unknown (can't remember) |
| **19b. Did you use your hands to:**<br><br>*Select all that apply.* | □ Vault corner of vehicle<br>□ Vault on to vehicle<br>□ Brace against vehicle<br>□ Other, specify _____<br>□ None<br>□ Unknown |
| **20. What portion of the vehicle first struck you?** | □ Front<br>□ Corner<br>□ Side<br>□ Rear<br>□ Unknown |
| **21. Where were you when you were struck?** | □ Stepping off the curb<br>□ On the shoulder<br>□ In the crosswalk area<br>□ In the road<br>□ On the sidewalk<br>□ Other, specify _____<br>□ Unknown |
| **22. When struck by the vehicle, which way was your chest/body facing?** | □ Facing vehicle<br>□ Facing away<br>□ Left side to vehicle<br>□ Right side to vehicle<br>□ Other, specify_____<br>□ Unknown |

| | |
|---|---|
| **23. When struck by the vehicle, which way was your head facing?** | □ Facing vehicle<br>□ Facing away<br>□ Left side to vehicle<br>□ Right side to vehicle<br>□ Other, specify_____<br>□ Unknown |
| **24. Where were your arms at impact?** | □ At sides (includes arm swing)<br>□ Folded across chest<br>□ Pushing/pulling/carrying an object<br>□ Raising to protect head<br>□ Extended to brace against vehicle<br>□ Other, specify: _____<br>□ Unknown |
| **25. Where were your legs at Impact?** | □ Together<br>□ Apart laterally<br>□ Apart right leg forward<br>□ Apart left leg forward<br>□ Both feet off ground<br>□ Other, specify_____<br>□ Unknown |
| **26. Can you describe your body's movement after being struck by the vehicle?** | *(text)* |
| **27. Where did you come to final rest** | *(text)* |

| Pedestrian Clothing and Accessories | |
|---|---|
| **28. What kind of shoes were you wearing?** | *(text)* |
| **29. What type and color of clothing were you wearing?**<br><br>*Head*<br>*Upper body*<br>*Lower body* | *(text)* |
| **30. Did you take any actions to increase your visibility to traffic?** | □ No<br>□ Wearing reflective clothing<br>□ Wearing bright colored clothing<br>□ Used lights<br>□ Other, specify_____ |
| **31. Were you wearing glasses, contacts, or sunglasses?** | □ No<br>□ Glasses/contacts for vision correction<br>□ Sunglasses<br>□ Other, specify: _____ |

| Environment | |
|---|---|
| **32. How often do you walk/ride this route?** | □ First time<br>□ Less than once a month<br>□ One to two times a month<br>□ One to three times a week<br>□ Most days |
| **33. When the crash occurs during Twilight or night: Did you see whether the vehicle that stuck you had its headlights on?**<br>*If "No" skip question 33a.* | □ Yes<br>□ No<br>□ Unknown |
| **33a. When the crash occurs during Twilight or night: Did you see the headlights before or after you entered the road?** | □ Before<br>□ After |
| **34. Was there a pedestrian signal where you crossed the road?**<br>*If "No" or "Unknown" skip to question 35.* | □ Yes<br>□ No<br>□ Unknown |
| **34a. Do you have to push a button to make the pedestrian signal work?** | □ Yes<br>□ No |
| **34b. Did you activate the pedestrian signal?** | □ Yes<br>□ No |
| **34c. Do you remember what the pedestrian signal status was when you entered the road?** | □ Indicating walk<br>□ Counting down<br>□ Flashing stop<br>□ Stop |
| **34d. Did the signal give you enough time to cross?** | □ Yes<br>□ No |

| Pedestrian Condition | |
|---|---|
| **35. Before the crash, how were you feeling?** | □ Normal<br>□ Other, specify _____ |
| **36. Do you think your mental status was clear leading up to the crash?** | □ Yes<br>□ No, specify _____ |
| **37. Did you feel that you were in a rush?** | □ Yes<br>□ No |
| **38. Would you say you are well rested or a little tired at the time of the crash?** | □ Very tired<br>□ Somewhat tired<br>□ Well rested |
| **39. What best describes your housing status?** | □ Private residence<br>□ Long term care facility<br>□ Group home<br>□ School or university housing<br>□ Worker housing<br>□ Homeless shelter<br>□ Unsheltered (On street, in a vehicle, or other place not meant for habitation)<br>□ Drug rehabilitation facility<br>□ Correctional facility<br>□ Psychiatric facility<br>□ Other, specify _____<br>□ Unknown |

| Trip Details | |
|---|---|
| **40. Why were you walking/riding the day of the crash?** | □ No car<br>□ No license<br>□ Faster to walk/ride than drive<br>□ Car not running<br>□ Exercise<br>□ Other, Specify _____ |
| **41. What was the main purpose of your walking/riding trip on the day of the crash?** | □ Commuting to/from work<br>□ Commuting to/from school<br>□ Recreation/Exercise<br>□ Restaurant/Bar<br>□ Personal errands (to/from the store, post office, etc.)<br>□ Drop off/pick up someone<br>□ Visiting a friend or relative<br>□ Walk the dog<br>□ Escort child to/from school<br>□ Other, specify: _____ |
| **42. Why did you choose the route you were taking?** | □ Most convenient<br>□ Shortest route<br>□ Nice scenery<br>□ Increased length for physical activity<br>□ Other, specify: _____ |
| **43. Did you feel safe walking/riding in this area before you were struck?** | □ Completely Safe<br>□ Concerned about traffic<br>□ Concerned about other risk, specify: _____<br>□ Not safe at all |
| **44. Did anything along this route surprise you the day of the crash?** | □ Placement of signs<br>□ Timing of signals<br>□ Pavement markings<br>□ Volume of traffic<br>□ Other, Specify _____ |

| Behavior | |
|---|---|
| **45. Can you estimate how many minutes a day you walk outside for transportation?** | □ Less than 5<br>□ 5 to 15<br>□ 15 to 30<br>□ 30 to 60<br>□ More than 60 |
| **46. When you walk, where do you go most often?** | □ Work/School<br>□ For exercise<br>□ Stores<br>□ Other, specify: _____ |
| **47. Do you use sidewalks or paths when one is available?** | □ Every time you walk<br>□ Most of the time<br>□ Some of the time<br>□ Hardly ever<br>Explain: |
| **48. Do you cross at the crosswalk when one is available?** | □ Every time you cross the street<br>□ Most of the time<br>□ Some of the time<br>□ Hardly ever<br>Explain: |
| **49. Do you wait for a walk signal when one is available?** | □ Every time you cross the street<br>□ Most of the time<br>□ Some of the time<br>□ Hardly ever<br>Explain: |
| **50. Which of the following modes of transportation do you use?**<br>*Select all that apply.* | □ Motor Vehicle (Car, SUV, Van, Truck)<br>□ Bike<br>□ Scooter/Other Micro Mobility<br>□ Bus<br>□ Train<br>□ Walk<br>□ Other, Specify _____ |

If the Non-Motorist was a pedestrian skip next page

If the Non-Motorist was riding a pedalcycle or personal conveyance continue to next page

| Pedalcycle or Personal Conveyance | |
|---|---|
| **51. Were you riding a bicycle or using a personal conveyance?** | □ Bicycle<br>□ Other type of cycle<br>□ Mobility aid device<br>□ Skates<br>□ Skateboard<br>□ Self-balancing board<br>□ Scooter (standing or seated)<br>□ Other |
| **52. Was it motorized?** | □ Yes<br>□ No<br>□ Unknown |
| **53. How many wheels did the bicycle or personal conveyance have?** | □ 0<br>□ 1<br>□ 2<br>□ 3<br>□ 4<br>□ 5<br>□ 6 or more<br>□ Unknown |
| **54. Did the bicycle or personal conveyance have any reflectors?** | □ None<br>□ Front □ Clear/White □ Red □ Amber □ Other<br>□ Rear □ Clear/White □ Red □ Amber □ Other<br>□ Side □ Clear/White □ Red □ Amber □ Other<br>□ Unknown |
| **55. Did the bicycle or personal conveyance have any lights?** | □ None<br>□ Front □ Clear/White □ Red □ Amber □ Other<br>□ Rear □ Clear/White □ Red □ Amber □ Other<br>□ Unknown |
| **55a. Do the lights flash?** | □ None<br>□ Front<br>□ Rear<br>□ Front and Rear<br>□ Unknown |
| **56. Were you wearing any protective equipment?** | □ Helmet What type of helmet _____<br>□ Pads □ Elbow □ Knee □ Shin □ Other_____<br>□ Eye wear<br>□ Face shield<br>□ Gloves<br>□ Wrist guards<br>□ Unknown |

| Non-Motorist | |
|---|---|
| **57. Sex** | □ Male<br>□ Female<br>□ Female, Pregnant, # of months ___ |
| **58. Height**<br>**Weight**<br>**Age** | _____<br>_____<br>_____ |
| **59. Race/Ethnicity** | □ White<br>□ Black or African American<br>□ Asian<br>□ Native Hawaiian or Other Pacific Islander<br>□ American Indian or Alaska Native<br>□ Hispanic or Latino<br>□ Middle Eastern or North African<br>□ Other<br>□ Unknown |

| | |
|---|---|
| **61. Were you injured?** | □ Yes<br>□ No<br>□ Unknown |
| **62. Were you transported directly from the crash scene for treatment?** | □ Yes<br>□ No<br>□ Unknown |
| **63. Did you receive any medical treatment?** | □ No<br>□ EMS at scene<br>□ Hospital<br>□ Medical clinic<br>□ Doctor's office<br>□ Treated by self<br>□ Unknown |
| **64. If treated at hospital, which describes level of treatment?** | □ Treated and released from emergency room<br>□ Admitted to hospital<br>Number of days _____<br>□ Unknown |
| **65. Did you miss any days of work or school as a result of the crash?** | □ No<br>□ Yes<br>Number of days _____<br>□ Not working prior to crash<br>□ Unknown |

OMB Control Number: 2127-0706
Expiration Date: 08/31/2025

## INDIVIDUAL INJURY DESCRIPTION

**Identify which Non-Motorist is being reported on here:**

PSU Number _____ Case Number _____ Non-Motorist Number ___

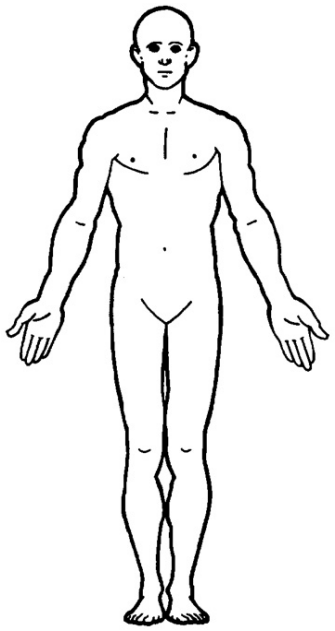
**Did Non-Motorist have any of the following injuries?**

☐ Cuts ☐ Abrasions ☐ Bruises ☐ Fractures ☐ Head/skull/brain ☐ Internal ☐ Sprains/strains ☐ Other

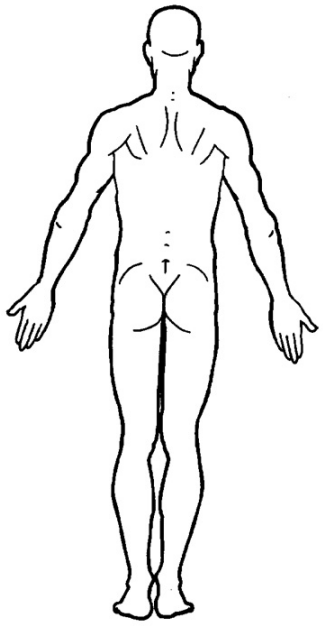
**Annotate Injury, Location and Source**

☐ No Injuries

**FRONT**



**RIGHT** **LEFT**



**LEFT** **RIGHT**

**BACK**

OMB Control Number: 2127-0706
Expiration Date: 08/31/2025

## INDIVIDUAL INJURY DESCRIPTION

**Identify which Non-Motorist is being reported on here:**

PSU Number _____ Case Number _____ Non-Motorist Number ___

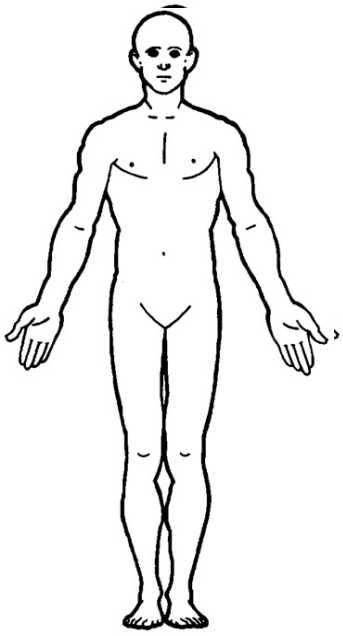
**Did Non-Motorist have any of the following injuries?**

☐ Cuts ☐ Abrasions ☐ Bruises ☐ Fractures ☐ Head/skull/brain ☐ Internal ☐ Sprains/strains ☐ Other

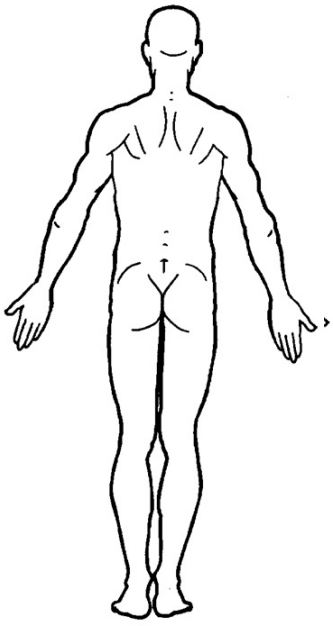
**Annotate Injury, Location and Source**

☐ No Injuries

**FRONT**



**RIGHT** **LEFT**



**LEFT** **RIGHT**

**BACK**