U.S. Department of Transportation

National Highway Traffic Safety Administration

DOT Auto Safety Hotline

Vehicle Owner's Questionnaire

To Report Vehicle Safety Defects
1-888-DASH-2-DOT
(1-888-327-4236)
INTERNET:www.nhtsa.dot.gov/hotline

FOR AGENCY USE ONLY 100148

Date Received	Repository ☐
AUG 29 2011 (10-SEP-2010)	Reference No. 10354873

OWNER INFORMATION (Type or Print)

Name		Daytime Telephone Number	E-mail Address
Address		Evening Telephone Number	
City: WINDSOCKET	State: RI	Zip Code:	

The information you provide will be used to identify potential safety-related defects. We may share your information with the applicable vehicle manufacturer during an investigation or recall in accordance with the routine uses described in the agency's Privacy Act notice. See 49 FR 53971 (Sep. 3, 2004).

VEHICLE INFORMATION

17 digit Vehicle Identification Number Located at bottom of windshield on driver's side	Make	Model	Model Year
1HGCM56897A	HONDA	ACCORD	2007

Date Purchased	Dealer's Name and Telephone Number			Engine: No: Cylinders	Fuel Type:
Original Owner ☐	Dealer's City	State	Zip Code		

Transmission Type	☐ Antilock Brakes ☐ Cruise Control	Powertrain	Multiple Failure:	Incident Date(s) 08-SEP-2010

FAILED COMPONENT(S)/PART(S) INFORMATION

Vehicle Component Code: 180000 VEHICLE SPEED CONTROL	Failure Mileage	Failure Speed
	52000	0

ADDITIONAL ITEMS TO BE COMPLETED WHEN REPORTING A TIRE FAILURE

Tire Make	Tire Model (Name or Number)	Tire Size (Example P215/65R15)
DOT No. (Example: DOTMAL9ABC036)	☐ Original Equipment ☐ Prior Repair	Failure Location:
Tire Component Code		Tire Failure Type:

ADDITIONAL ITEMS TO BE COMPLETED WHEN REPORTING A CHILD SEAT FAILURE

Make:	Date Manufactured:	Model No./Name:
Seat Type:	Installation System:	
Child Seat Component Code:	Failed Part:	

APPLICABLE INCIDENT INFORMATION

(Please describe in detail the incident(s), Failure(s), Crash(es), and injury(ies).)

Crash	Fire	Number of Persons Injured	Number of Deaths	Reported to Police
[X] Yes ☐ No	☐ Yes [X] No	1	0	Y

Narrative Description of Incident(S), Crash(es), and Injury(ies).
Please describe (1) events leading up to the failure, (2) failure and its consequences, and (3) what was done to correct the failure; i.e, parts repaired or replaced (and if old part is available).

TL*THE CONTACT OWNS A 2007 HONDA ACCORD. THE CONTACT STATED THAT WHILE AT A COMPLETE STOP AND READY TO MAKE A RIGHT TURN, THE VEHICLE ACCELERATED ON ITS OWN. THE CONTACT APPLIED ON THE BRAKES AND THEY DID NOT ENGAGE IN ORDER TO STOP THE VEHICLE. THE VEHICLE DROVE OVER A CURB, A BUSY INTERSECTION AND THEN CRASHED INTO A TREE. THE CONTACT SUSTAINED BRUISES TO HER FACE AND BODY. THE VEHICLE WAS DESTROYED AND WAS TOWED FROM THE CRASH SITE. HONDA HAD NOT BEEN CONTACTED AND A POLICE REPORT WAS AVAILABLE. THE FAILURE AND THE CURRENT MILEAGE WAS 52000.

Include, if available: Police/Fire Department Report, Photos, and Repair Invoice. ATTACH ADDITIONAL SHEETS IF NECESSARY

Landmark
Medical Center

December 29, 2010

[redacted]

Woonsocket, RI [redacted]

Date of Service: 09/08/10
Amount Due: $2120.90
Account#: [redacted]

Dear [redacted]

Our records indicate your account is past due. Please pay your balance within 14 days or your account will be referred to a collection agency.

Please indicate your payment method:

( ) Check or money order enclosed, made payable to Landmark Medical Center.

( ) Charge to my credit card (MasterCard, Visa, Discover, American Express) Please circle one.

Card #_____

Expiration date:_____

Signature:_____

Date:_____

CVV2/CID _____ 3 or 4 digit#
Last 3 digits found on the signature panel on the back of your card. AMEX 3 digits above account number on the front of the card.

If you need to make payment arrangements or have any questions, please contact the Customer Service Department of Landmark Medical Center, 1-401-769-4100 X 6679, Monday – Friday, 8:00 AM to 4:00 PM.

Thank you for your immediate attention to this matter.

PFS/Customer Service Rep.

Woonsocket Unit
PFS/Customer Service
115 Cass Avenue
Woonsocket, RI 02895

MEDICAL IMAGING ASSOCIATES, INC
PO BOX 9137
BROOKLINE, MA 02446-9137

1-877-240-7592

8636-0177

Date: 09/19/2010
Account #: [redacted]
Phone #: [redacted]
Service date(s): 09/08/2010,09/08/2010

0101

RETURN SERVICE REQUESTED

RE: [redacted]

Balance Due: $97.00

[redacted]

WOONSOCKET, RI [redacted]

MEDICAL IMAGING ASSOCIATES, INC
PO BOX 9137
BROOKLINE, MA 02446-9137

8636-0177*T1B0KD37H000204

Dear [redacted]

In order for us to bill your insurance properly for services rendered
at LANDMARK MEDICAL CENTER - W, we need more complete information.
The services include (but are not limited to):
CHEST PA & LAT ;SPINE CERVICAL AP & LAT ;
Please fill in the following applicable information or call
the number listed above as soon as possible.

Date of Birth: _____ SS # _____-_____-_____

Primary Ins Co Name: _____

Primary Ins Co Address: _____

City:_____ State: ___ Zip: _____ ID#: _____ _____

Group #: _____ Subscriber's Name: _____ Rel to Patient: _____

Secondary Ins Co Name: _____

Secondary Ins Co Address: _____

City:_____ State: ___ Zip: _____ ID#: _____ _____

Group #: _____ Subscriber's Name: _____ Rel to Patient: _____

Are these services work related? Y__ N__. Auto? Y__ N__ If either question is yes, please answer below:

Name & Address of Insurance Carrier:_____ _____

_____ _____

Claim File #: _____ Date of Injury: _____ _____

Claim Adjuster: _____ Phone #: _____ _____

Thank you very much for your prompt attention.

PLEASE NOTE: We will bill your insurance company as a service for you.
You may be responsible for any additional balances.

8636-0177*T1B0KD37H000204