

U.S. Department
of TransportationNational Highway
Traffic Safety
Administration

DOT Auto Safety Hotline

Vehicle Owner's Questionnaire (VOQ)

NATIONWIDE 1-888-DASH-2-DOT
1-888-327-4236
www.nhtsa.dot.gov/hotline

FOR AGENCY USE ONLY 118

Date Received

14-NOV-2000

 Od_or _____
 rt_dt _____
 od_rt _____
 up_ltr _____

Reference No.

874921

 Do you authorize NHTSA to provide a copy of report to the manufacturer of your vehicle? YES NO
 In the absence of an authorization, NHTSA WILL NOT provide your name and address to the vehicle manufacturer.

Signature of Owner _____ Date ____/____/____

VEHICLE INFORMATION

Vehicle Ident. No. (VIN.) <small>(Listed at front of windshield or drivers side)</small>	Vehicle Make	Vehicle Model	Vehicle Year	Current Odometer Reading
2T1BR1BE4WC085153	TOYOTA	COROLLA	1998	

Purchase Date	Dealer's Name _____	Engine Size (CID/CC/L) _____	<input type="checkbox"/> Turbo <input type="checkbox"/> Diesel <input type="checkbox"/> Gas <input type="checkbox"/> Fuel Injection
<input checked="" type="checkbox"/> New <input type="checkbox"/> Used	City _____ State _____ Zip Code _____	No. Cylinders _____	

Transmission Type	Antilock Brakes	Restraint System	Cruise Control	Drive Train	Vehicle Type	Body Style
<input type="checkbox"/> Manual <input type="checkbox"/> Automatic	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> 3-Point Belt <input type="checkbox"/> Driverside Airbag <input type="checkbox"/> Passengerside Airbag <input type="checkbox"/> Motorbell <input type="checkbox"/> 2-Point Belt	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Front <input type="checkbox"/> Rear <input type="checkbox"/> 4-Wheel	<input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Minivan <input type="checkbox"/> Other _____ <input type="checkbox"/> Sport Ult <input type="checkbox"/> Truck <input type="checkbox"/> Motorcycle	<input type="checkbox"/> 2-Door <input type="checkbox"/> 4-Door <input type="checkbox"/> Stationwagon <input type="checkbox"/> Pick Up Truck <input type="checkbox"/> Other _____

FAILED COMPONENT(S)/PART(S) INFORMATION

Component 12112100	Part Name(s) INTERIOR SYSTEMS:PASSIVE RESTRAINT:AIR BAG:SIDE DOOR	Location <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Front <input type="checkbox"/> Rear	Failed Part(s) <input type="checkbox"/> Original <input type="checkbox"/> Replacement
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No. of Failures	Date(s) of Failure(s) _____ Mileage at Failure(s) 13000 Vehicle Speed at Failure(s) _____	Failed Part(s) Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	NHTSA Previously Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No
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APPLICATION INCIDENT INFORMATION

(Please describe in detail the incident(s), Failure(s), Crash(es), and injury(ies) on the back of this form)

Crash <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Fire <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Number of Persons Injured	Number of Fatalities	Estimated Property Damage	Reported to Police <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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NARRATIVE DESCRIPTION OF FAILURE(S), INCIDENT(S), INJURY(IES)

WHILE WAITING TO MAKE A LEFT TURN, VEHICLE WAS HIT ON DRIVER'S SIDE DOOR, AND THERE WAS NO DEPLOYMENT OF SIDE AIR BAGS. VEHICLE HAS BEEN REPAIRED. PLEASE PROVIDE ANY FURTHER INFORMATION.*AK

CONTINUED ON BACK PLEASE

The Privacy Act of 1974-Public Law 93-579 This information is requested pursuant to authority vested in the National Highway Traffic Safety Act and subsequent amendments. You are under no obligation to respond to this questionnaire. Your response may be used to assist the NHTSA in determining whether a manufacturer should take appropriate action to correct a safety defect. If the NHTSA proceeds with administrative enforcement or litigation against a manufacturer, your response, or a statistical summary thereof, may be used in support of the agency's action.



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National Highway Traffic Safety Administration

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FOR AGENCY USE ONLY 118

Date Received: 14-NOV-2000
Office: [Redacted]
Reference No.: 874921

OWNER INFORMATION (Type or Print)

[Redacted] 655320
[Redacted]
[Redacted]

Work Number: [Redacted]
Home: [Redacted]

Do you authorize NHTSA to provide a copy of report to the manufacturer of your vehicle? YES NO
In the absence of [Redacted] name and address to the vehicle manufacturer.
Signature of Owner: [Redacted] Date: 11/24/2000

VEHICLE INFORMATION

Vehicle Ident. No. (VIN): 2T1BR1BE4WC085153
Vehicle Make: TOYOTA
Vehicle Model: COROLLA
Vehicle Year: 1998
Current Odometer Reading: 15,060

Purchase Date: 6-27-98
Dealer's Name: Smithtown Toyota
360 E. JERICHO TPKE
City: Smithtown State: NY Zip Code: 11787
Engine Size (CID/CC/L): 1.8
No. Cylinders: 4
 Turbo
 Diesel
 Gas
 Fuel Injection

Transmission Type: Automatic
Antilock Brakes: No
Restraint System: 3-Point Belt, Driverside Airbag, Passengerside Airbag
Cruise Control: Yes
Drive Train: Front, Rear, 4-Wheel
Vehicle Type: Car
Body Style: 4-Door

FAILED COMPONENT(S)/PART(S) INFORMATION

Component: 12112100
Part Name(s): INTERIOR SYSTEMS:PASSIVE RESTRAINT:AIR BAG:SIDE DOOR
Location: Left
Failed Part(s): Original

No of Failures: 1
Date(s) of Failure(s): 7/27/2000
Mileage at Failure(s): 13000
Vehicle Speed at Failure(s): 1 MPH PER HR
Failed Part(s) Available? Yes
NHTSA Previously Contacted? No

APPLICATION INCIDENT INFORMATION

(Please describe in detail the incident(s), Failure(s), Crash(es), and injury(ies) on the back of this form)

Crash: Yes
Fire: No
Number of Persons Injured: 1
Number of Fatalities: 0
Estimated Property Damage: 5,400
Reported to Police: Yes

NARRATIVE DESCRIPTION OF FAILURE(S), INCIDENT(S), INJURY(IES)

WHILE WAITING TO MAKE A LEFT TURN, VEHICLE WAS HIT ON DRIVER'S SIDE DOOR, AND THERE WAS NO DEPLOYMENT OF SIDE AIR BAGS. VEHICLE HAS BEEN REPAIRED. PLEASE PROVIDE ANY FURTHER INFORMATION.*AK

CONTINUE ON BACK IF NEEDED

The Privacy Act of 1974-Public Law 93-579 This information is requested pursuant to authority vested in the National Highway Traffic Safety Act and subsequent amendments. You are under no obligation to respond this questionnaire. Your response may be used to assist the NHTSA in determining whether a manufacturer should take appropriate action to correct a safety defect. If the NHTSA proceeds with administrative enforcement or litigation against a manufacturer, your response, or a statistical summary thereof, may be used in support of the agency's action.

Toyota Motor Sales USA
Claims Dept. A-108
19001 South Western Avenue
Torrance, California - 90509



Dear Sirs,

September 22, 2000

On July 27, 2000, I was in a car accident with my 1998 Toyota Corolla (4door) that I leased two years ago, with the option to buy from Smithtown Toyota Corporation at 360 East Jericho Turnpike, Smithtown, N.Y. -11787. Their phone number is (631) 724-3300.

The accident was not my fault. I was making a left turn into a driveway, when a suburban car behind me hit me in the drivers side of my car. The side airbags, which were an optional feature, that cost an additional \$250 00 to the buyout price, did not protect me because it did not inflate. Consoquently, I hit my head hard on the side of the car, and had to be rushed to the hospital for stitches to the head plus other injuries.

On August 7th, I called the General Manager at Smithtown Toyota, whose name is Dennis Dogger. I was informed he could not help me. I was told to call Toyota Motor Corporation at 1-800-331-4331. A woman named Alana gave me a case #200008071108 and told me someone would be in touch with me. I had told Alana the car was getting repaired at American Auto Body at 1367 Middle Country Road-Centereach, N.Y. 11720(631-732-8594).

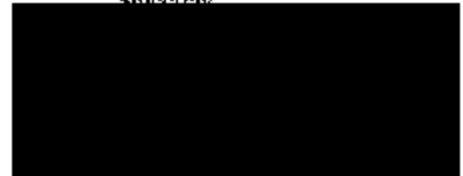
On August 11th, a very rude person by the name of Walter Kemmesap called and said he could not inspect the car until the following week and that he did not make house calls. I had to leave my car at the repair shop. This was not necessary because the car would have already been repaired by the time he could get there. I explained I had many pictures of the damages to the car, plus he could contact the people who repaired it. All I wanted was an explanation as to why the airbag did not work. He refused. I called back later that same day, got an apology from someone called Sal. He said he would look into the matter and get back to me. NOBODY called back.

On August 21st, I called the Motor Corporation once again and spoke to Rob, who could offer no help either, except to give me your address.

I am very disappointed that a corporation as large as Toyota would not be interested in a customers complaint on the safety of one of your vehicles. The way everyone has been passing me back and forth, with no help, has disillusioned me greatly. Up until now, I thought Toyota had a wonderful reputation. My son owns a Toyota van, my daughter and son-in-law each own a Toyota Camry and Corolla.

I hope you will be able to resolve my problem as soon as possible. Thank you for your time.

Sincerely,



cc:js

TOYOTA

Writer's Direct Dial (310) 618-5037
Writer's Direct Fax (310) 381-6317

Toyota Motor Sales, U.S.A., Inc.
19001 South Western Avenue
PO Box 2722
Torrance, CA 90501-2722
310 468-4500
310 468-7800 Fax

September 28, 2000

[REDACTED]
Seiden, NY 11784

RE: Accident of July 27, 2000

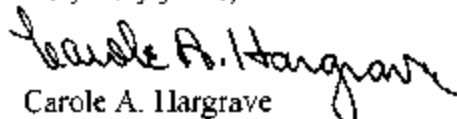
Dear Ms. [REDACTED]

This letter is in response to yours of September 22, 2000, in regards to the above reference accident. In order for us to respond, we will need the following information.

1. Copy of the traffic accident report
2. Copy of the repair invoice or estimate
3. Photographs or color copies (not photocopies) of the damaged vehicle, or the current location of the vehicle in order that we may inspect.
4. Name, age, height, weight and injuries of driver and passengers.
5. Year, model and vin# of the vehicle involved.

As soon as we received this information, we will review and respond to your inquiry.

Very truly yours,



Carole A. Hargrave
Claims Administrator
Legal Department
Toyota Motor Sales, U.S.A., Inc.

TOYOTA

Writers Direct Telephone (310) 468-5027
Writers Direct Fax (310) 381-6317

Toyota Motor Sales, U.S.A., Inc.
17001 South Western Avenue
P.O. Box 2722
Torrance, CA 90509-2722
310 468-4000
310 168-7800 Fax

October 13, 2000



RE: Date of Loss: July 27, 2000
Vehicle: 1998 Toyota Corolla
Vin #: 2T1BR1BE4WC085153

Dear Ms. Marino

I am in receipt of and thank you for the information you furnished me with in regards to your accident of July 27, 2000.

It is our understanding that you were attempting to turn left when another vehicle attempted to pass you on the left. The other vehicle struck the Corolla at the front of the left door and fender area.

We have reviewed the photographs of your vehicle, along with the police report and repair estimate. The impact was not to the B pillar of the vehicle. The impact was to the front portion of the drivers door and fender area. There was no direct impact or intrusion to the B pillar (center pillar) of the vehicle to deploy the side air bag. The side air bag deploys as a result of direct impact to the B pillar

We are sorry to hear about your injuries, however, the type of injuries you sustained would not have been prevented by the deployment of the side air bag. The side air bags are designed to protect the Thoracic area. They are not designed to prevent head and hand injuries.

Thank you for allowing us to address your concerns.

Very truly yours,

A handwritten signature in black ink that reads "Carole A. Hargrave".

Carole A. Hargrave
Claims Administrator
Legal Department
Toyota Motor Sales, U.S.A., Inc.

New York State Department of Motor Vehicles
POLICE ACCIDENT REPORT

MV-104A (7/96)
DMV COPY

CERTIFIED
RECORDED SECTION
SUFFOLK COUNTY POLICE DEPARTMENT

Local Codes
00-397746

Vehicle #2 DRIVER

1	Accident Date Month: 7, Day: 27, Year: 00	Day of Week THU	Time 1:45 PM	AM <input type="checkbox"/> PM <input checked="" type="checkbox"/>	No. of Vehicles 2	No. Injured 1	No. Killed 0	Non-Highway <input type="checkbox"/>	Not Investigated <input type="checkbox"/>	Accident Reconstructed <input type="checkbox"/>	Left Scene <input type="checkbox"/>	Police Photos <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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2	VEHICLE 1 Name: [Redacted] Address: [Redacted] City/Town: [Redacted] State: NY Date of Birth: 1/1/16 Sex: M Unlicensed <input type="checkbox"/>	VEHICLE 2 Name: exactly as printed on license Section okay Address: 20 Box 973 City/Town: Shoreham NY 11786 State: NY Date of Birth: 5/20/70 Sex: M Unlicensed <input type="checkbox"/>
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3	16125412 Name: SAA Date of Birth: 1/1/16 Address: [Redacted] City/Town: [Redacted] State: NY Zip Code: [Redacted]	106 Prince Rd Name: Mosgor, Conway Date of Birth: 1/1/16 Address: 106 Prince Rd City/Town: Rocky Pt NY 11778 State: NY Zip Code: [Redacted]
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4	W820WK NY 98 Toyota 4000 639	B476P NY 92 Ford Subn 328
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5	Check if involved vehicle is: <input type="checkbox"/> more than 85 inches wide <input type="checkbox"/> more than 34 feet long <input type="checkbox"/> operated with an overweight permit <input type="checkbox"/> operated with an overdimension permit	Check if involved vehicle is: <input type="checkbox"/> more than 85 inches wide <input type="checkbox"/> more than 34 feet long <input type="checkbox"/> operated with an overweight permit <input type="checkbox"/> operated with an overdimension permit	Check the diagram below that describes the accident or draw your own diagram in the space provided (9). Number the vehicles
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6	VEHICLE 1 DAMAGE CODES Box 1 - Point of Impact Box 2 - Most Damage Enter up to three more Damage Codes	VEHICLE 2 DAMAGE CODES Box 1 - Point of Impact Box 2 - Most Damage Enter up to three more Damage Codes	ACCIDENT DIAGRAM Rear End, Left Turn, Right Angle, Right Turn, Head On, Overtaking, Left Turn, Right Turn, Sideswipe
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7	VEHICLE DAMAGE CODING: 1-13. See diagram on right. 14. UNDERCARRIAGE 15. TRAILER 16. OVERTURNED 17. DEMOLISHED 18. NO DAMAGE 19. OTHER	Diagram showing vehicle damage coding locations (1-13) on a car chassis.
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8	Reference Marker	DMV USE ONLY	County: SUFFOLK City/Town/Village: Brookhaven Route No. or Street Name: 14 20: Crowley Rd 21: Medford Nearest Intersecting Route/Street: Rt 112
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9	TICKET/ARREST <input type="checkbox"/> OPR1 <input type="checkbox"/> OPR2 <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> BICYCLIST <input type="checkbox"/> OTHER	Violation Section(s)	Accident Description/Officer's Notes: veh #1, E.B. Crowley Rd making left turn into cemetery when veh #2 tried passing veh #1, collides into side of veh #1. NO GPS
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BY	TO	Names - If Deceased, Give Date of Death
1	4	veh #1
3	4	Rosale Cynthia
6	4	veh #2 driver Larry
3	4	veh #2
3	4	NAZIN Brynam

SIGN HERE	Officer's Rank and Name PO Michael J. [Signature]	Badge/ID No. 4815	Department 05101	Precinct/Post Group/Zone 60	Station/Beat/Sector 1-7	Reviewing Officer [Signature]	Date/Time 7/27/00
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PT. Name: MARINO, KATHLEEN
ED#: 279335

603215559
07/27/2000
473-1320 Ext. 4045

MATHER HOSPITAL
DEPARTMENT

PATIENT'S COPY

AFTERCARE INSTRUCTIONS TO THE PATIENT

NOTE: The examination and treatment you have received in the Emergency Department have been rendered on an emergency basis only, and are not intended to be a substitute for or an effort to provide complete medical care. It is recommended that when necessary and advised that you contact your own doctor for follow up. It is important that you let him check you again, and that you report to him any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. Your doctor may obtain the results of all x-ray, lab, or other diagnostic studies done today, upon request. If your condition worsens, or new symptoms appear, or should you not recover as expected, and you cannot contact your doctor, PLEASE RETURN TO THE EMERGENCY DEPARTMENT. Meanwhile, FOLLOW THE INSTRUCTIONS BELOW as indicated for you.

Your preliminary diagnosis is SITING SCALP ABRASION, TRAUMA

- WOUND AND LACERATION CARE (cuts, abrasions, burns, etc.)
 - Keep the dressings clean and dry.
 - Elevate the wound to help relieve soreness and help speed wound healing.
 - Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by you must report to your doctor right away.
 - If dressings need to be changed you should:
 - Charge them Call your doctor
 - Suture # 2 removal in 10 days. You may have your sutures removed by your private physician or you may return to Mather Hospital between the hours of 8:00 A.M. - 11:00 P.M. Please call 473-1320, Ext. 4044, before coming in. Give your name and the date of your ED visit, so that we can have your chart available.
 - You have received a Tetanus/Diphtheria Booster. You may expect minimal swelling, pain, a low grade fever or redness at the site of injection. If these symptoms occur, apply ice packs to the area for 24 hours.
- BETA STREP THROAT CULTURE ONLY
Call the Laboratory for result between the hours of 8:30 A.M. and 3:30 P.M. - but not sooner than 48 hours after the culture is taken. 473-1320, EXT. 4138.
- Immunization Instruction Sheet

- SPRAIN AND SEVERE BRUISES
 - Elevate the injured part to lessen swelling. If pillows flatten, use chair cushions with pillows or blankets for comfort.
 - Ice packs also help prevent swelling, especially during the first 48 hours. Place ice in plastic or rubber bag, cloth cover.
 - If you have a cast, keep it perfectly dry at all times.
- BACK AND NECK INJURY INSTRUCTIONS
 - Use heat or cold on the injured area - whichever seems to help the most. Be careful not to burn yourself.
 - Rest as much as possible until you are improved.
 - Avoid positions and movements that make the pain worse.
 - Relax emotionally - if you are tense the problem will only be worse.
 - Gentle but firm massage will increase circulation in sore muscles, and soon will help to clear the soreness.

- HEAD INJURY INSTRUCTIONS
 - Report to your doctor immediately if anything listed occurs (even within several months):
 - Persistent vomiting, stiff neck, fever.
 - Unequal pupils (one pupil large, one small).
 - Confusion or unusual drowsiness.
 - Convulsions or unconsciousness.
 - Stumbling or other problem with normal use of arms or legs; or areas of skin numbness.
 - Note: Waken patient hourly the first night to check for these signs.

- GENERAL INSTRUCTIONS
 - Call tomorrow to arrange an appointment at your private physician's office or Dr. E. K. Sullivan
 - Follow label instructions for any prescription given by the Emergency Physician.
 - Avoid any use of the injured part.
 - Allow only limited use of the part.
 - You need not necessarily limit activity.
 - Tylenol/Aspirin for pain or fever
 - OK to use.
 - Not to be used.

X-RAY REPORT GIVEN TO YOU BY THE HOSPITAL IS A PRELIMINARY READING BY THE EMERGENCY SERVICE PHYSICIAN. IN THE EVENT THAT THE RADIOLOGIST (X-RAY SPECIALIST) REPORT REVEALS NEW FINDINGS YOU WILL BE CONTACTED AND YOUR ATTENDING DOCTOR NOTIFIED.

OTHER INSTRUCTIONS: Examination to wound 3 days
Wound check in 3 days
Return to ER if all instructions

I hereby acknowledge receipt of the instructions indicated above and I expressly understand and agree that such instructions are not a substitute for continued medical care and that it will be necessary for me to select a private physician and arrange with him to continue my treatment.

I further acknowledge and understand that only those instructions which are checked are applicable to me and that those instructions which are not checked may not be applicable for my particular condition.

Date 7-27-00 Time 4:55 AM/PM PM -Br [Signature]

MAKE CHECKS PAYABLE TO:

PROFESSIONAL RADIOLOGY GROUP, P.C.
 635 BELLE TERRE RD
 SUITE 102
 PT. JEFFERSON, NY 11777-1984
 PHONE #: (631) 331-6262
 TIN: 11-3337095

ADDRESS SERVICE REQUESTED

PATIENT: [REDACTED]
 PLACE OF SERVICE: JT MATHER HOSPITAL
 JT MATHER HOSPITAL

ADDRESSEE:

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT		
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> VISA	
CARD NUMBER	AMOUNT	
SIGNATURE	EXP. DATE	
STATEMENT DATE	PAY THIS AMOUNT	ACCT.#
08/16/00	70.46	5350268
PAGE # 1	SHOW AMOUNT PAID HERE \$	

REMIT TO:

|||||
 MARINO, KATHLEEN
 39 MONTCLAIR DRIVE
 SELDEN, NY 11784

|||||
 PROFESSIONAL RADIOLOGY GROUP, P.C.
 635 BELLE TERRE RD
 SUITE 102
 PT. JEFFERSON, NY 11777-1984

0267492 5966

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	DR	EXAM CODE	DESCRIPTION	AMOUNT
07/27/00	4	847.0	Balance forward last statement	
07/27/00	4	816.01	7205026 CERVICAL SPINE	49.09
			7314026 FINGER(S), MIN TWO V	21.37

PROFESSIONAL RADIOLOGY GROUP, P.C.
 635 BELLE TERRE RD
 SUITE 102
 PT. JEFFERSON, NY 11777-1984
 PHONE #: (631) 331-6262 QUESTIONS? CALL BETWEEN 1-4 PM
 PATIENT: MARINO, KATHLEEN
 ACCT.#: 5350268

BALANCE DUE
 70.46

THIS IS FOR THE READING OF YOUR X-RAYS AND IS SEPARATE FROM THE HOSPITAL. PLEASE NOTIFY US WITH YOUR NO FAULT INSURANCE INFORMATION SO WE MAY FILE DIRECTLY WITH YOUR INSURANCE COMPANY. THANK YOU.

EDWARD H. GLENN, M.D.
 DAVID SCHERER, M.D.
 ALEXANDRA PERKINS, M.D.

HERMAN TREITEL, M.D.
 JORDAN HABER, M.D.
 JOSEPH COMUNALE, M.D.

JOSEPH M. CARRUCCI, M.D.
 MARK DECKER, M.D.
 TAMARA MOHUCHY, M.D.