INCIDENT REPORT

ACCIDENT INFORMATION

ACCIDENT DATE	TIME OF LOSS
POLICYHOLDER NAME	PRIMARY CONTACT Name: Phone: E-mail:
LOCATION OF ACCIDENT	

INJURED PERSON INFORMATION

NAME			E-MAIL
ADDRESS			PHONE NUMBER
DATE OF BIRTH	CURRENT AGE	HEIGHT	WEIGHT
DOES VISITOR WEAR GLASSES? ☐ YES ☐ NO	IF "YES" WHAT ARE THE GLASSES WORN FOR? ☐ Reading ☐ Driving ☐ Other		WAS VISITOR WEARING GLASSES AT TIME OF THE ACCIDENT? ☐ YES ☐ NO
WAS VISITOR TAKING OR USING ☐ Alcohol ☐ Prescription Drugs ☐ Non-Prescription Drugs			
IF CHECKED, EXPLAIN			
LIST ANY PHYSICAL DISABILITIES NOTED			

ADDITIONAL ACCIDENT INFORMATION

DESCRIBE WALKWAY/FLOOR WHERE ACCIDENT OCCURRED AND ANY DEFECTS (include floor coverings, if any)		
WAS FLOOR CLEAN, DRY AND FREE OF DEBRIS? ☐ YES ☐ NO	DESCRIBE WEATHER AT TIME OF ACCIDENT	DESCRIBE LIGHTING AT TIME OF ACCIDENT
DID VISITOR MAKE ANY COMMENT ABOUT THE CAUSE OF THE ACCIDENT? ☐ YES ☐ NO IF "YES," EXPLAIN		
WHAT WAS VISITOR DOING AT TIME OF ACCIDENT (Check all that apply) ☐ Walking ☐ Running ☐ Carrying heavy, bulky or awkward objects ☐ Other		
WHAT HAPPENED?		
GIVE DETAILED DESCRIPTION OF INJURY		
GIVE DETAILED DESCRIPTION OF TYPE OF SHOES WORN AND CONDITION AT TIME OF ACCIDENT (SNEAKERS, SANDALS, HIGH HEELS, LEATHER OR RUBBER SOLES, ETC.		
WAS AN INSPECTION DONE? ☐ YES ☐ NO	WERE PHOTOGRAPHS TAKEN? ☐ YES ☐ NO	

WITNESS INFORMATION (If more than on witness, list information on separate sheet of paper)

NAME(S) OF WITNESS	
ADDRESS(ES)	PHONE NUMBER(S)
IF WITNESS (ES) TALKED TO VISITOR, WHAT WAS SAID?	

EMPLOYEE INFORMATION

DID ANY EMPLOYEE ASSISTING THE INJURED VISITOR SPEAK TO THE VISITOR? ☐ YES ☐ NO IF "YES," WHAT WAS SAID BY THE EMPLOYEE?	
NAME OF EMPLOYEE	DEPARTMENT
ADDRESS	PHONE NUMBER
IF THERE WAS A SPILL NAME OF EMPLOYEE WHO CLEANED IT UP	DEPARTMENT
ADDRESS	PHONE NUMBER

TREATMENT INFORMATION

WERE PARAMEDICS OR AN AMBULANCE CALLED? ☐ YES ☐ NO	IF "YES," NAME OF PERSON WHO CALLED THEM	TIME CALL WAS MADE ☐ A.M. ☐ P.M.
APPROXIMATELY HOW LONG AFTER THE CALL DID THEY ARRIVE?	APPROXIMATELY HOW LONG AFTER ACCIDENT DID THEY ARRIVE?	
NAME OF AMBULANCE SERVICE AND/OR NAME(S) OF PARAMEDICS		
IF TREATMENT WAS PERFORMED ON SIDTE, WHAT WAS DONE?		
IF VISITOR WAS TRANSPORTED TO HOSPITAL, GIVE NAME, ADDRESS AND PHONE NUMBER OF HOSPITAL		
TREATMENT GIVEN AT HOSPITAL		
WAS DESCRIPTION/HISTORY OF ACCIDNT GIVEN AT HOSPITAL? ☐ YES ☐ NO	IF "YES," NAME OF PERSON WHO GAVE IT	
IF VISITOR TOLD PARAMEDICS/HOSPITAL PERSONEL WHAT CAUSED THE ACCIDENT, WHAT WAS SAID?		
NOTE ANY COMMENTS MADE BY THE PARAMEDICS/HOSPITAL STAFF REGARDING THE ACCIDENT?		
WAS VISITOR HOSPITALIZED? ☐ YES ☐ NO		
NAMES OF TREATING PHYSICIAN(S) AND PHONE NUMBER(S) (Attach additional sheet if necessary)		

ADDITIONAL COMMENTS

SIGNATURE OF PERSON COMPLETING REPORT

PRINT OR TYPE NAME

TITLE

DATE SIGNED

☐ P.M.
☐ A.M.
TIME COMPLETED