McGOWAN ALLIED
Specialty Insurance

FIRST REPORT OF INCIDENT

McGowan Allied Specialty Insurance
20595 Lorain Road
Fairview Park, OH 44126
(440) 895-3636
E-Mail Form to: claims@mcgowanallied.com

Name of Insured: _____

Policy Number: _____

Location:	Date of Incident Time of Incident: ☐ AM ☐ PM	**DID THIS TAKE PLACE DURING** ☐ Pre-Opening ☐ During event hours ☐ After close

The following must be completed.

NAME OF PERSON COMPLETING REPORT: _____

TELEPHONE NUMBER OF PERSON NAMED ABOVE: _____

INJURED PERSON INFORMATION

Does this injured person have medical insurance? ☐ YES ☐ NO

If yes please provide: Name of insurance company: _____

Policy # _____

Last Name	First	Middle	Telephone Number ☐ Single ☐ Married
Address	City	State	Zip
Age	Date of Birth	☐ Male ☐ Female	

☐ Parent/Guardian ☐ Chaperone

GUARDIAN/PARENT IF ABOVE IS UNDER 18:

Were they present when incident occurred? ☐ Yes ☐ No

Last Name	First	Middle	Telephone Number ☐ Single ☐ Married
Address	City	State	Zip
Age	Date of Birth	☐ Male ☐ Female	

INJURY INFORMATION

INCIDENT LOCATION	INCIDENT	PRIMARY INJURY	BODY PART INJURED
	☐ Assault ☐ Fall (different level) ☐ Fall (same level) ☐ Caught in, on, between ☐ Collision (with object) ☐ Slip/Trip/Fall ☐ Struck by falling/flying object ☐ Other (please specify):	☐ Abrasion ☐ Burn ☐ Contusion ☐ Electrical Shock ☐ Laceration ☐ Nausea ☐ Pain ☐ Seizures ☐ Strain/Sprain ☐ Tooth/Mouth ☐ Other:	☐ Ankle ☐ Arm ☐ Ear ☐ Elbow ☐ Eye ☐ Foot ☐ Hand ☐ Hip ☐ Knee ☐ Leg ☐ Shoulder ☐ Wrist ☐ Back ☐ Face ☐ Finger/Toe ☐ Head ☐ Neck ☐ Nose ☐ Tooth ☐ Torso

MEDICAL SERVICES GIVEN			ACTION TAKEN	
☐ Bandaged ☐ Ointment/ anti-septic ☐ Ice Pack	☐ Rest ☐ Wrapped ☐ None	Treated by:	☐ EMS transport ☐ Refusal of care ☐ Patient requested EMS ☐ Released to parent	☐ Police ☐ Report only ☐ Other:

STATEMENT OF INJURED PERSON

Name of person making statement ______________________ & their relationship ______________________

STATEMENT: ____

____
Signature of injured or parent/guardian/chaperone

____
Date

____
Signature EMPLOYEE Taking Report Printed

____
Time Report Taken

____
Date

____
Name of Employee

EMPLOYEES ON DUTY AT TIME OF INCIDENT

POSITION	NAME (PRINT)	WITNESSED INCIDENT	TALKED TO OR ASSIST-ED INJURED PERSON	TALKED TO OR HEARD FROM OTHER GUESTS	INSPECTED AREA WHERE INCIDENT OCCURRED
GM Present ☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Assist. Mgr.		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Assist. Mgr.		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DESCRIBE HOW INCIDENT OCCURED

POST-INCIDENTACTIONSTAKEN

Photographs Taken: ☐ Yes ☐ No

Video Saved ☐ Yes ☐ No

Witness Statements Taken ☐ Yes ☐ No (if yes, attach)

Manager Completing This Report: ______________________ Date: ______________

Home Address: ______________________

Cell Phone: ______________________

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WITNESS STATEMENT

Name of insured: _____

Location:	Date of Incident:	Did this take pace during: ☐ Pre-Opening ☐ During Event Hours ☐ After Close

Witness Name:			Date:
Department:			
Home Address:	City:	State:	Zip:
Home Phone:			

Accident Details

Name of Injured Party:		
Date of Accident:	Approximate Time of Accident:	
Does the witness know the injured party?	☐ Yes	☐ No

Witness Statement

How did the accident occur? What did the witness observe? What did they do?
(Use additional sheets of paper, if more space is needed)

Witness Signature:	Date: