

FIRST REPORT OF INCIDENT

Submit form to appropriate contact above.

Name of Insured: _____

Policy Number: _____

Location:	Date of Incident	DID THIS TAKE PLACE DURING <input type="checkbox"/> Pre-Opening <input type="checkbox"/> During event hours <input type="checkbox"/> After close
	Time of Incident: <input type="checkbox"/> AM <input type="checkbox"/> PM	

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	<input type="checkbox"/> Single <input type="checkbox"/> Married
Address		City	State	Zip
Age	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> 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	<input type="checkbox"/> Single <input type="checkbox"/> Married
Address		City	State	Zip
Age	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female	

INJURY INFORMATION

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

MEDICAL SERVICES GIVEN

ACTION TAKEN

<input type="checkbox"/> Bandaged <input type="checkbox"/> Ointment/anti-septic <input type="checkbox"/> Ice Pack	<input type="checkbox"/> Rest <input type="checkbox"/> Wrapped <input type="checkbox"/> None	Treated by: _____	<input type="checkbox"/> EMS transport <input type="checkbox"/> Refusal of care <input type="checkbox"/> Patient requested EMS <input type="checkbox"/> Released to parent	<input type="checkbox"/> Police <input type="checkbox"/> Report only <input type="checkbox"/> Other:
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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 <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assist. Mgr.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assist. Mgr.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

DESCRIBE HOW INCIDENT OCCURED

POST-INCIDENT ACTION TAKEN

Photographs Taken: ☐ Yes ☐ No

Witness Statements Taken

☐ Yes ☐ No (if yes, attach)

Video Saved ☐ Yes ☐ No

Manager Completing This Report: _____ Date: _____

Home Address: _____

Cell Phone: _____

FIRST REPORT OF INCIDENT

Submit form to appropriate contact above.

WITNESS STATEMENT

Name of insured: _____

Location:	Date of Incident:	Did this take place during: <input type="checkbox"/> Pre-Opening <input type="checkbox"/> During Event Hours <input type="checkbox"/> After Close
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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?			<input type="checkbox"/> Yes	<input type="checkbox"/> 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: