

## FIRST REPORT OF INCIDENT

Submit form to appropriate contact above.

Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Location:	Date of Incident	<b>DID THIS TAKE PLACE DURING</b> <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			
Assist. Mgr.		<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			

### 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: \_\_\_\_\_



McGowan Allied Specialty Insurance  
 140 Fountain Parkway N., Suite #570 St. Petersburg, FL 33716  
 T.H.E Insurance Company  
 (844) 749-5796  
 9300THEClaims@Sedgwick.com

Everest  
 (800) 267-1676  
 5201EverestNational@Sedgwick.com

## 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

Witness Name:			Date:
Department:			
Home Address:	City:	State:	Zip:
Home Phone:			
<b>Accident Details</b>			
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: \_\_\_\_\_