

Submit form to appropriate contact above.

## FIRST REPORT OF INCIDENT

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: \_\_\_\_\_

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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

## DESCRIBE HOW INCIDENT OCCURED

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

Submit form to appropriate contact above.

## FIRST REPORT OF INCIDENT

### 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: