

ACCIDENT REPORT

Premises, Facilities and Events

INJURED PERSON <small>If more than one person injured, list other persons in "Injuries" section of this report</small>			INSURANCE INFORMATION <small>(office use only)</small>
Name of Injured Person			Insurance Company
Address			Policy Number
City	State	Zip	Telephone

ACCIDENT DATE AND LOCATION			
Date Of Accident	Time Of Accident	a.m. p.m.	Location Of Accident
Date Reported	Time Reported	a.m. p.m.	

INJURIES -- describe the nature of any apparent injuries	
Name Of Injured Person	Name Of Other Injured Person
Injury	Address
First Aid administered by	Injury
Where taken after accident	First Aid administered by
Transported by	Where taken after accident
	Transported by

INDOOR	
Type Of Lighting <small>(describe)</small>	Quality Of Lighting <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Excellent
Type Of Floor <small>(describe)</small>	<input type="checkbox"/> Concrete <input type="checkbox"/> Carpet <input type="checkbox"/> Tile <input type="checkbox"/> Wood <input type="checkbox"/> Other
Condition Of Floor <small>(describe)</small>	<input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Worn / Damaged <input type="checkbox"/> Freshly Waxed <input type="checkbox"/> Other

OUTDOOR	
Weather Conditions <small>(describe)</small>	<input type="checkbox"/> Clear <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> Sleet <input type="checkbox"/> Other
Visibility <small>(describe)</small>	<input type="checkbox"/> Daylight <input type="checkbox"/> Dark <input type="checkbox"/> Clear <input type="checkbox"/> Fog <input type="checkbox"/> Other
Type Of Surface <small>(describe)</small>	<input type="checkbox"/> Concrete / Asphalt <input type="checkbox"/> Grass / Ground <input type="checkbox"/> Curbing <input type="checkbox"/> Stairs / Ramp <input type="checkbox"/> Other
Condition Of Surface <small>(describe)</small>	<input type="checkbox"/> Dry <input type="checkbox"/> Wet / Standing Water <input type="checkbox"/> Icy / Snowy <input type="checkbox"/> Hole / Damaged
Surface	<input type="checkbox"/> Other

ACCIDENT DESCRIPTION -- complete a separate description section for each person interviewed

Describe How The Accident Occurred

Source Of Information

Injured Party

What Caused The Accident?

ACCIDENT DESCRIPTION -- complete a separate description section for each person interviewed

Describe How The Accident Occurred

Source Of Information

Witness

Name _____

Address _____

Phone _____

What Caused The Accident?

ACCIDENT DESCRIPTION -- complete a separate description section for each person interviewed

Describe How The Accident Occurred

Source Of Information

Witness

Name _____

Address _____

Phone _____

What Caused The Accident?

ACCIDENT DESCRIPTION -- complete a separate description section for each person interviewed

Describe How The Accident Occurred

Source Of Information

Employee Witness

Other Witness

Name _____

Work
Location /
Address _____

Phone _____

What Caused The Accident?

PERSON COMPLETING THIS REPORT

Name

Date