



Incident Report

Insured Info

Policy Number: _____
Name: _____
Address: _____
Email: _____
Phone: _____

Incident

Date/Time of Incident: _____
Place of Incident: _____
Type of Injury: (i.e. fell, stuck, pushed) _____
Weather/Surface Condition: _____
First Aid: _____ Yes or _____ No
Medical Care: (other than first aid) _____
Disposition: _____ Fatality (if yes, Ambulanced to:) _____
_____ Personal Auto (if yes, to:) _____
_____ Continued on premise activity
_____ Refused Treatment

Describe Accident: _____

Witnesses

1. Name, Address, City, State, Zip, Phone# _____

2. Name, Address, City, State, Zip, Phone# _____

Injured Parties

1. Injured Party Type: (i.e. customer, vendor, passerby)

Name, Address, City, State, Zip, Phone# _____

2. Injured Party Type: (i.e. customer, vendor, passerby)

Name, Address, City, State, Zip, Phone# _____

Property Damage

Property Damages: (describe the type of property and damage) _____
Fire Dept Involved: _____
Fire Dept Report #: _____
Police Dept Involved: _____
Police Dept Report #: _____
Recommendation for Correct Action: _____

Comment: _____
