ILOVEVACATIONS

ACCIDENT INCIDENT REPORT FORM

Use this form to report accidents, injuries, medical situations, or traffic incidents.
If possible, a report should be completed within 24 hours of the event.

Date of Report: ___________________, 20_____

PERSON INVOLVED

Full Name: ____________________ Address: _______________________________________

Social Security No. ______________________________ Job Title ___________________

☐ Other: ______________________________

Phone: (_____) _____-______ E-Mail: ____________________

THE INCIDENT

Date of Incident: ___________________, 20_____ Time: _____:______ ☐ AM ☐ PM

Location: _______________________________________

Describe the Incident: ____

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INJURIES

Was anyone injured? ☐ Yes ☐ No

If yes, describe the injuries. Include which side of your body was injured: ____________

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WITNESSES

Were there witnesses to the incident? ☐ Yes ☐ No

If yes, enter the witnesses' names and contact info: ________________________________

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POLICE / MEDICAL SERVICES

Police Notified? ☐ Yes ☐ No If yes, was a report filed? ☐ Yes ☐ No Was medical treatment provided? ☐ Yes ☐ No ☐ Refused

If yes, where was medical treatment provided? ☐ On site ☐ Hospital ☐ Other: __________

Medical Treatment Provider Name: ____

Medical Treatment Location Address: ____

PERSON FILING REPORT

Signature: ______________________________Date: ________________

Print Name: ______________________________

OFFICE USE ONLY

Report received by: _____________________Date: ____________________, 20_____

Follow-up action taken: ____

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