

INCIDENT REPORT FORM

Please return completed form to:

Email: contact@protectivity.com

INSURED: _____ POLICY NUMBER: _____

DATE REPORTED: _____ TIME REPORTED: _____

EXACT LOCATION: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ DAY OF WEEK: _____

INCIDENT REPORT COMPLETED BY: _____ INCIDENT REPORTED TO: _____

TIME INCIDENT LOCATION INSPECTED: _____ INSPECTED BY: _____

PART 1: INJURED PERSON DETAILS

NAME: _____

ADDRESS: _____

TELEPHONE NO: (HOME) _____ (BUSINESS) _____ (MOBILE) _____

DATE OF BIRTH: _____ MALE FEMALE

Walking Stick Glasses Carrying Goods Intoxicated Other Impairments

PART 2: WITNESS * DETAILS

* Eyewitnesses witnessed the incident; circumstantial witnesses witnessed the events leading up to or following the incident. Additional witnesses' details should be provided on attachment.

ATTACH STATEMENTS FOR ADDITIONAL COMMENTS

NAME OF WITNESS TO ACCIDENT: _____

ADDRESS OF WITNESS: _____

TELEPHONE NO: (HOME) _____ (BUSINESS) _____ (MOBILE) _____

TYPE OF WITNESS: EYE WITNESS CIRCUMSTANTIAL WITNESS

RELATIONSHIP TO INJURED PERSON: _____

(If more than one witness, please provide details) _____

IF ANOTHER PARTY RESPONSIBLE, PLEASE PROVIDE DETAILS: _____

PART 3: PERSONAL INJURY DETAILS

PART OF BODY INJURED (Place tick in appropriate box)

Head & Neck	<input type="checkbox"/>	Hip	<input type="checkbox"/>	Hands/ Fingers	<input type="checkbox"/>
Eyes or Face	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	Knee	<input type="checkbox"/>
Back & Trunk	<input type="checkbox"/>	Arms / Wrists	<input type="checkbox"/>	Feet and toes	<input type="checkbox"/>

If Other, or multiple, please describe: _____

NATURE OF INJURY (Place tick in appropriate box)

Multiple	<input type="checkbox"/>	Minor Bruise - Not Disabling	<input type="checkbox"/>	Concussion/Unconscious (Serious)	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	Major Bruising - Disabling	<input type="checkbox"/>	Burns/Scalds – requiring medical attention	<input type="checkbox"/>
Sprain	<input type="checkbox"/>	Minor Cut/Laceration - No Stitches	<input type="checkbox"/>	Superficial	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	Cut/Laceration requiring Stitches	<input type="checkbox"/>	No Apparent Injury	<input type="checkbox"/>
Ligament Damage	<input type="checkbox"/>	Minor Concussion	<input type="checkbox"/>		

If Other, describe: _____

DESCRIPTION OF and SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT (as described by injured party)

DESCRIPTION OF INCIDENT (by you or independent witness – including an un-biased view on whether the injured person contributed to the injury)

WAS INJURED PERSON TAKEN TO: TREATMENT BY FIRST AIDER DOCTOR/HOSPITAL AMBULANCE
OTHER (Please describe):

If Other, describe: _____

NAME OF FIRST AIDER/ PERSON ATTENDING: _____ CONTACT NO: _____

IF THIRD PARTY/CONTRACTOR AT FAULT: THIRD PARTY/CONTRACTOR'S NAME: _____

THIRD PARTY/CONTRACTOR'S INSURANCE DETAILS: _____

PART 4: PROPERTY DAMAGE (complete if there is property damage)

ITEM DAMAGED: _____

DETAILS: _____

IF VIEWED AND BY WHOM: _____

PHOTOS TAKEN AND BY WHOM: _____

PART 5: LOCATION OF INCIDENT (Please tick in appropriate box)

Car Park	<input type="checkbox"/>	Entrance/Exit	<input type="checkbox"/>	Stairs	<input type="checkbox"/>
Car Park Ramps	<input type="checkbox"/>	Office Areas	<input type="checkbox"/>	Escalators	<input type="checkbox"/>
Bar	<input type="checkbox"/>	Internal Ramp	<input type="checkbox"/>	Elevators	<input type="checkbox"/>
Toilet Areas	<input type="checkbox"/>	Children's Play Area	<input type="checkbox"/>	Restaurants	<input type="checkbox"/>
Food areas	<input type="checkbox"/>	Balcony	<input type="checkbox"/>	Gaming areas	<input type="checkbox"/>
Dance Floor	<input type="checkbox"/>				

If Other, describe: _____

PART 6: TYPE OF INCIDENT (Please tick in appropriate box)

Slip and Fall of Person: Cause

Chips	<input type="checkbox"/>	Lack of Barrier	<input type="checkbox"/>	Uneven Floor	<input type="checkbox"/>
Ice Cream	<input type="checkbox"/>	Rainwater on floor	<input type="checkbox"/>	Tripped over Object	<input type="checkbox"/>
Beverage	<input type="checkbox"/>	Barrier/Signs	<input type="checkbox"/>	Steps/Stairs	<input type="checkbox"/>
Floor Slippery (Surface)	<input type="checkbox"/>	Vegetable/Fruit items	<input type="checkbox"/>	Car Park Stops/Bollards	<input type="checkbox"/>
Inadequate Lighting	<input type="checkbox"/>	Other Food	<input type="checkbox"/>	No apparent Reason	<input type="checkbox"/>
Person running	<input type="checkbox"/>	Vomit	<input type="checkbox"/>		

If Other, describe: _____

OR Caught in:

Door	<input type="checkbox"/>	Escalator/Elevator	<input type="checkbox"/>
Machinery	<input type="checkbox"/>	Other	<input type="checkbox"/>

If Other, describe: _____

Stepping on or Striking Against:

Display Stands	<input type="checkbox"/>	Escalator/Elevator	<input type="checkbox"/>	Other	<input type="checkbox"/>
Sharp Edges/Protruding Objects	<input type="checkbox"/>	Doors	<input type="checkbox"/>		

If Other, describe: _____

Other:

Falling Objects

Water Damage

If Falling objects, please describe: _____

Type of surface:

Marble

Tile

Carpet

Speed hump

Terrazzo

Timber

Bitumen

Dirt/grass/garden

Slate

Vinyl

Concrete

Other

If Other, describe: _____

WAS INJURED PERSON:

Reasonable

Upset

Add relevant comments:

Aggressive

CLEANER ON DUTY: _____

CLEANING SUPERVISOR: _____

TIME LOCATION LAST INSPECTED: _____

TIME LAST CLEANED: _____

PLEASE ATTACH WRITTEN STATEMENT FROM CLEANER (If appropriate)

RECORD OF INCIDENT:

Video/closed circuit

Photo

None