

INCIDENT / ACCIDENT REPORT FORM

Please return completed form to:
Email: enquiries@rogerrich.co.uk



Roger Rich & Co Ltd. 2A Marston House
Cromwell Park, Chipping Norton OX7 5SR

PLEASE COMPLETE ALL APPLICABLE SECTIONS OF THE BELOW FORM

INSURED: _____ POLICY NUMBER: _____

ADDRESS: _____

TELEPHONE NO: _____

EMAIL ADDRESS: _____

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: _____

ANIMAL IN YOUR CARE/CUSTODY THAT CAUSED THE DAMAGE

NAME: _____
(Surname) (Given Names)

ADDRESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

DATE OF BIRTH: _____ (approx or guess if unknown) MALE FEMALE

WALKING STICK GLASSES CARRYING GOODS INTOXICATED

OTHER IMPAIRMENTS

PART 1: OWNER OF DAMAGED/INJURED PROPERTY/ANIMAL DETAILS

NAME: _____
(Surname) (Given Names)

ADDRESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

DATE OF BIRTH: _____ (approx or guess if unknown) 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: _____
(Surname) (Given Names)

ADDRESS OF WITNESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

TYPE OF WITNESS: EYE WITNESS CIRCUMSTANTIAL WITNESS

RELATIONSHIP TO INJURED PERSON/ANIMAL: _____

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

IF ANOTHER PARTY RESPONSIBLE, PLEASE PROVIDE DETAILS: _____

PART 3: PERSONAL/ANIMAL INJURY DETAILS

IF APPLICABLE TYPE OF ANIMAL _____ BREED _____

ANY PRE-EXISTING MEDICAL CONDITIONS _____
_____**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): _____

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: _____

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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 If Falling objects, please describe: _____

Water Damage

Type of surface

- | | | | | | | | |
|----------|--------------------------|--------|--------------------------|----------|--------------------------|-------------------|--------------------------|
| Marble | <input type="checkbox"/> | Tile | <input type="checkbox"/> | Carpet | <input type="checkbox"/> | Speed hump | <input type="checkbox"/> |
| Terrazzo | <input type="checkbox"/> | Timber | <input type="checkbox"/> | Bitumen | <input type="checkbox"/> | Dirt/grass/garden | <input type="checkbox"/> |
| Slate | <input type="checkbox"/> | Vinyl | <input type="checkbox"/> | Concrete | <input type="checkbox"/> | Other | <input type="checkbox"/> |

If Other, describe: _____

WAS INJURED PERSON Reasonable Upset Aggressive Add relevant comments

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

I/WE DECLARE THAT THESE PARTICULARS ARE TRUE TO THE BEST OF OUR KNOWLEDGE:

NAME (BLOCK CAPITALS) _____

SIGNATURE: _____

DATE: _____