

## PUBLIC LIABILITY INCIDENT REPORT FORM

Please return completed form to:

Email: [petbusiness@woodgate-clark.co.uk](mailto:petbusiness@woodgate-clark.co.uk)

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

Sharp Edges/Protruding Objects

Escalator/Elevator

Other

Doors

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

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