

**ACCIDENT/INCIDENT REPORT FORM**

Date of incident: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Name of injured/affected person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Date of birth: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Who was injured person?(circle one) Guest Employee

Type of injury/loss: \_\_\_\_\_

Details of incident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Police called? Yes \_\_\_ No \_\_\_

Injury requires physician/hospital visit? Yes \_\_\_ No \_\_\_

Name of physician/hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Physician/hospital phone number: \_\_\_\_\_

\_\_\_\_\_  
Signature of injured/affected party

\_\_\_\_\_  
Date

\*No medical attention was desired and/or required. Ambulance refused.

\_\_\_\_\_  
Signature of injured party

\_\_\_\_\_  
Date