

VISITOR/CLIENT POST INCIDENT/ACCIDENT INITIAL INFORMATION FORM - DA 3000

OFFICE OF RISK MANAGEMENT - UNIT OF RISK ANALYSIS AND LOSS PREVENTION

GENERAL LIABILITY – FOR AGENCY USE ONLY

- This form is NOT for use in reporting a claim. The claim reporting form can be found at: www.laorm.com
- Required for all incidents/accidents except vehicle accidents for which a police report serves as the proper documentation.
- Keep completed forms on file at the location where the audit/compliance review will occur.

(PLEASE TYPE OR PRINT)

1. AGENCY NAME and LOCATION CODE: _____

2. DATE and TIME of INCIDENT/ACCIDENT: _____ 3. REPORTING DATE: _____

4. VISITOR/CLIENT NAME (LAST, FIRST): _____

5. VISITOR/CLIENT ADDRESS: _____

6. VISITOR'S/CLIENT'S TELEPHONE #: _____

7. VISITOR'S/CLIENT'S DETAILED DESCRIPTION OF HOW ACCIDENT OCCURRED:

8. DID ANY EMPLOYEE ASK THE VISITOR/CLIENT IF HE/SHE WAS INJURED? ___Y ___N

9. DID THE VISITOR/CLIENT VERBALLY EXPRESS AN INJURY TO ANY PART OF HIS/HER BODY? ___Y ___N

(IF NO, SKIP TO Q. 10)

A. WHICH PART OF HIS/HER BODY WAS INJURED? PLEASE BE SPECIFIC (e.g., RIGHT FOREARM, LEFT WRIST, LOWER RIGHT ABDOMEN) _____

B. WAS MEDICAL CARE OFFERED? ___Y ___N

1. DID THE VISITOR/CLIENT ACCEPT MEDICAL CARE? ___YES ___NO

10. WERE THERE ANY WITNESS(ES)? ___Y ___N (IF NO, SKIP TO Q. 11)

A. WITNESS'S NAME, ADDRESS, and TELEPHONE # (use additional sheet if needed)

B. WITNESS STATEMENT(S) ATTACHED? ___Y ___N

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11. DETAILED DESCRIPTION OF INCIDENT/ACCIDENT LOCATION _____

A. IS THIS LOCATION IN A STATE-OWNED OR LEASED BUILDING?

B. IS THIS SPACE SHARED WITH NON-STATE EMPLOYEES? ___Y ___N

12. DID THE PERSON CONDUCTING THE INVESTIGATION OBSERVE ANYTHING THAT WAS DIFFERENT THAN THE VISITOR'S/CLIENT'S/WITNESS'S ACCOUNT? ___Y ___N IF YES, PLEASE PROVIDE A BRIEF SUMMARY:

13. CHECK THE APPROPRIATE ENVIRONMENTAL CONDITION(S) THAT IS/ARE APPLICABLE TO THE INCIDENT/ACCIDENT:

- RAINING SUNNY CLOUDY FOGGY COLD HOT LIGHTING WIND
- OTHER WEATHER CONDITION(S) _____ WEATHER NOT A FACTOR

14. CHECK THE APPROPRIATE BOX(ES) THAT PERTAINS TO THE INCIDENT/ACCIDENT:

- STAIRS PARKING LOT GARAGE SIDEWALK ELEVATORS GRATING
- SPONSORED ACTIVITY DORMITORY WAITING ROOM WALKWAYS RAILINGS
- FURNITURE LIQUID ON FLOOR - TYPE OF LIQUID _____
- FLOORING - DESCRIBE THE TYPE OF FLOOR AND TYPE OF WAX _____
- EQUIPMENT (SPECIFY TYPE) _____ STATE-OWNED? ___Y ___N
- OTHER CONDITION(S): _____

15. IF THE INCIDENT/ACCIDENT INVOLVED ITEMS THAT CAN BE RETAINED (e.g., furniture, muffler, exam table), THE CLAIMS UNIT REQUIRES THAT THE ITEM BE TAGGED WITH THE DATE OF INCIDENT/ACCIDENT AND NAME OF VISITOR/CLIENT.

IF THE STATE-OWNED ITEM IS BROKEN OR DAMAGED, IT MUST BE PLACED IN A SECURED AREA AFTER BEING TAGGED.

THE TAG CANNOT BE REMOVED OR THE BROKE/DAMAGE ITEM CANNOT BE SURPLUS/DISCARDED UNTIL NOTIFIED BY THE CLAIMS UNIT.

IF APPLICABLE, WERE THESE STEPS FOLLOWED? ___Y ___N

16. WAS THE VISITOR/CLIENT AUTHORIZED TO BE IN THIS AREA? ___Y ___N

17. DID ANY EMPLOYEE OBSERVE ANYTHING BEFORE/AFTER THAT IS REVELANT TO THE ACCIDENT? ___Y ___N

(IF NO, SKIP TO Q. 18)

A. WAS A STATEMENT OBTAINED AND ATTACHED? ___Y ___N

18. DID THE SUPERVISOR OR AGENCY SAFETY OFFICER RECEIVE A REPORT OF ANY OBSERVED CONDITIONS? ___Y ___N

19. WERE PICTURES TAKEN AND ARE THEY ATTACHED TO REPORT? ___Y ___N

20. NAME AND POSITION OF EMPLOYEE FILLING OUT THIS REPORT:

DATE