GUEST INJURY/ACCIDENT REPORT

TO BE USED FOR ALL INJURIES OR ACCDENTS REPORTED BY GUESTS.
DO NOT USE THIS FORM TO SUBMIT EMPLOYEE INJURY CLAIMS.

Guest Information

Last Name	First Name	M / F	Telephone Number (Area Code)
			( ) -

Address	City	State	Zip Code

Reporting Information

Today's Date (Month / Day / Year)	Person completing this form (Last Name / First Name / Job Title)
/ /	

When does the guest state that the Incident occurred? (Month / Day / Year / Time)	Exact Location of Incident
/ / : ○ AM ○ PM	

Details of Incident

State exactly the sequence of events leading up to the accident. What was the guest doing? Include the size, weight, and type of equipment or materials involved. Describe the injury, part(s) of the body involved, and specify right or left side.

_____

_____

_____

Witnesses

Name, address and telephone numbers of witnesses or person having knowledge of this injury/accident:

_____

_____

Conditions

What conditions contributed to the accident?

○ Unsafe equipment or facilities	○ Slipping or falling	○ Hazardous Personal Attire
○ Lighting/Decreased Visibility	○ Choking	○ Medical Condition

First Aid/Medical Attention

Was First Aid administered? ○ Yes ○ No Name of person who administered First Aid: _____

Describe First Aid Action(s) taken: _____

_____

Did Police Respond? ○ Yes ○ No Police Dept. Report # _____ Did Fire/EMT Respond? ○ Yes ○ No

Did the guest leave the restaurant in an ambulance? ○ Yes ○ No

Destination: ○ Guest did not provide this information ○ Home ○ Hospital (supply name if known)_____

Signature

_____

Signature of Person Reporting Incident / Date Signature of Company Officer / Date