

# Incident Report



NOTE: This is not an insurance claims form. It is for your internal use only.

## FACILITY WHERE INCIDENT OCCURRED

Name of Facility: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

## INJURED PERSON/CRIME VICTIM

Name: \_\_\_\_\_  If a minor, please provide name of contact person below:  
Phone: \_\_\_\_\_  
 Home  Work  Mobile  Home  Work  Mobile  
Description (include individual's height, weight, clothing, shoes, glasses, physical impairments): \_\_\_\_\_

## INCIDENT DETAILS

Date of Incident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_  AM  PM Weather Conditions (if outdoors): \_\_\_\_\_  
Specific Location (e.g., floor, room, area, etc.): \_\_\_\_\_  
Type of Incident (check one):  Slip/Trip/Fall  Crime  Vehicle Accident  Burn  Altercation  Other \_\_\_\_\_  
Description of Incident (note contributing factors such as items being carried, climbing/reaching for items, etc.): \_\_\_\_\_

Description of Injury or Property Damage: \_\_\_\_\_

Photos Taken:  Yes  No (if no, explain why not.) \_\_\_\_\_

Witnesses:  Yes  No (if yes, list below.) \_\_\_\_\_

Name: _____	Name: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile

## MEDICAL ATTENTION PROVIDED, IF ANY

Professional Medical Attention Requested:  Yes  No (if yes, explain.) \_\_\_\_\_

First Aid Measures Applied:  Yes  No (if yes, explain.) \_\_\_\_\_

Ambulance:  Yes  No Hospital: \_\_\_\_\_

## REPORTING/REVIEW CONTACT INFORMATION

Reported by: _____ (signature of injured person/crime victim)	Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile	Date: ____/____/____
Reported to: _____ (please print)	Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile	Date: ____/____/____
Reviewed by: _____ (please print)	Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile	Date: ____/____/____

Need to file a claim?

Call the Nationwide® claims unit 24/7 at 1-800-421-3535.