



8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-585-2849 • Fax 877-452-6909
After Hours Claim Reporting: 877-243-8182
CDA@primeis.com

INCIDENT/ACCIDENT REPORTING FORM

General Information

Name of Insured: _____

Contact Name: _____

Insured's Address: _____

City: _____ State _____ Zip: _____

Phone number: _____ Best time to contact: _____

Policy Number: _____ Effective Date of Policy: _____

Description of Property Damaged

Name of Injured Party: _____

If a minor, legal guardian's name: _____

Address: _____

Employer: _____

Home Phone: _____ Business Phone: _____

Description of Property: _____

Description of Damage and Accident

Date of Property Damage: _____ Time of Property Damage: _____

Service or Operations Provided: _____

Describe in detail how the accident happened (use reverse if necessary): _____

Describe the injured's mental status at the time of the accident:

Confused Calm Panicked Aggressive Other: _____

Describe Evacuation: _____

Describe location of the site where the accident occurred: _____

Describe the weather: _____

Temperature (estimate if necessary): _____ degrees Fahrenheit



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Did equipment contribute in any way to the accident? [radio] Yes [radio] No

If yes, please describe: _____

Did the injured party contribute to the accident in any way? [radio] Yes [radio] No

If yes, please describe: _____

Did the injured party state that he or she contributed to the accident in any way? [radio] Yes [radio] No

If yes, please describe: _____

Did another participant contribute to the injury? [radio] Yes [radio] No

If yes, please describe: _____

Were any photographs taken? [radio] Yes [radio] No

If yes, please enclose all photographs.

Activity Time Lost: [radio] None [radio] 1/2 Day or More [radio] Ended Participation

Describe any first aid given (include a list of any medications given): _____

Did the injured party refuse first aid or evacuation? [radio] Yes [radio] No

If yes, please describe: _____

Does the injured take any medications or have any allergies? [radio] Yes [radio] No

If yes, please describe: _____

Is this a re-injury of an old condition? [radio] Yes [radio] No

Employees on site at time of accident:

Table with 3 columns: Name, Age, Experience. Includes three rows of blank lines for data entry.

Has the injured party been at this location before? [radio] Yes [radio] No

If yes, indicate frequency: _____

Does the injured party currently have medical insurance? [radio] Yes [radio] No

If yes, with what company?: _____

Signature: _____ Title: _____

Print Name: _____ Date: _____