CUSTOMER/VENDOR ACCIDENT REPORT

Please complete and return to Human Resources within 24 hours or the next business day following the accident

Privileged & Confidential: This incident report is subject to the attorney-client privilege and the attorney product work doctrine, and is prepared in anticipation of litigation for ultimate transmittal to defense counsel.

This form is to be filled out by the MOD at the time of the incident

Full Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email Address: _____

Date of Injury: _____ Time of Injury: _____AM/PM

Location of Accident: _____

Specific injury/illness and part of body affected. (e.g. Second degree burns on right arm, tendonitis on left elbow, lead poisoning, etc.)

_____

_____

Equipment, materials and/or chemicals the customer/vendor came into contact with when the event or exposure occurred. (e.g. Debris on the floor, water, ladder, etc.)

_____

_____

Specific activity the customer/vendor was performing when the event or exposure occurred. (e.g. Walking down the stairs, walking on the sales floor, etc.)

_____

_____

How did the injury/illness occur? Describe the sequence of events. Specify the object(s) or exposure which directly produced the injury/illness.

_____

_____

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Was another person involved in the injury/illness? ☐ Yes ☐ No

If "Yes", Name: _____ Phone #: _____

Were there any witnesses to the injury/illness? ☐ Yes ☐ No

If "Yes", please attach statements written from each witness.

Witness Name: _____ Phone #: _____

Witness Name: _____ Phone #: _____

Did the customer/vendor require medical attention? ☐ Yes ☐ No

If "Yes", please complete the following information:

Was 911 called? ☐ Yes ☐ No

Were campus police and/or LB Fire called to the scene? ☐ Yes ☐ No

Was the customer/vendor transported to the hospital? ☐ Yes ☐ No

If "Yes", please complete the following information:

Medical Facility: _____

_____	_____	_____
M.O.D. Print Name	M.O.D. Signature	Date

This section to be completed by Human Resources

Referred to Forty-Niner Shops, Inc. insurance provider? ☐ Yes ☐ No

Is video surveillance available? ☐ Yes ☐ No

If "Yes", is the video secured? ☐ Yes ☐ No

Was the customer/vendor contacted for follow-up? ☐ Yes ☐ No

If "Yes", document the date and statement received by the customer/vendor:

_____

_____

_____

_____	_____
Human Resources Signature	Date