

# 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](http://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