



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](mailto: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 Injured Party

Name of Injured Party: \_\_\_\_\_

If a minor, legal guardian's name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Employer: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Business Phone: (     ) \_\_\_\_\_

## Description of Accident

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

Activity Participating In: \_\_\_\_\_

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

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

If yes, please describe: \_\_\_\_\_

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

If yes, please describe: \_\_\_\_\_



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

If yes, please describe: \_\_\_\_\_

Did another participant contribute to the injury?  Yes  No

If yes, please describe: \_\_\_\_\_

Were any photographs taken?  Yes  No

If yes, please enclose all photographs.

Activity Time Lost:  None  ½ Day or More  Ended Participation

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

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

If yes, please describe: \_\_\_\_\_

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

If yes, please describe: \_\_\_\_\_

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

Employees on site at time of accident:

Name	Age	Experience
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

If yes, indicate frequency: \_\_\_\_\_

Does the injured party currently have medical insurance?  Yes  No

If yes, with what company?: \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_