**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**
* **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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B. WITNESS STATEMENT(S) ATTACHED? \_\_\_Y \_\_\_N

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**and is prepared in anticipation of litigation.**

11. DETAILED DESCRIPTION OF INCIDENT/ACCIDENT LOCATION

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A. IS THIS LOCATION IN A  STATE-OWNED OR  LEASED BUILDING?

B. IS THIS SPACE SHARED WITH NON-STATE EMPLOYEES? \_\_\_Y \_\_\_N

12. IS THE PERSON COMPLETING REPORT TRAINED IN ACCIDENT INVESTIGATION? \_\_\_\_\_\_Y \_\_\_\_\_\_ N

13. 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:

14. 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

15. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. 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

17. WAS THE VISITOR/CLIENT AUTHORIZED TO BE IN THIS AREA? \_\_\_Y \_\_\_N

18. 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

19. DID THE SUPERVISOR OR AGENCY SAFETY OFFICER RECEIVE A REPORT OF ANY OBSERVED CONDITIONS? \_\_\_Y \_\_\_N

20. WERE PICTURES/VIDEO TAKEN AND ARE THEY ATTACHED TO REPORT? \_\_\_Y \_\_\_N

21. NAME AND POSITION OF EMPLOYEE FILLING OUT THIS REPORT:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

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