



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 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: _____