

Insure That Farm Liability – INCIDENT REPORT FORM

POLICY HOLDER: _____

DATE REPORTED: _____ TIME REPORTED: _____

EXACT LOCATION: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ DAY OF WEEK: _____

INCIDENT REPORTED BY: _____ INCIDENT REPORTED TO: _____

TIME INCIDENT LOCATION INSPECTED: _____ INSPECTED BY: _____

FAX TO PROCLAIM

1300 858 329

PART 1: INJURED PERSON DETAILS (also use for owner of damaged property if liability claim for damaged property)

NAME: _____
(Surname) (Given Names)

ADDRESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

DATE OF BIRTH: _____ (approx or guess if unknown) MALE FEMALE

WALKING STICK GLASSES CARRYING GOODS OTHER IMPAIRMENTS

PART 2: WITNESS * DETAILS

* Eyewitnesses witnessed the incident; circumstantial witnesses witnessed the events leading up to or following the incident. Additional witnesses' details should be provided on attachment.

ATTACH STATEMENTS FOR ADDITIONAL COMMENTS

NAME OF WITNESS TO ACCIDENT: _____
(Surname) (Given Names)

ADDRESS OF WITNESS: _____

TELEPHONE NO: (Home) _____ (Business) _____ (Mobile) _____

TYPE OF WITNESS: EYE WITNESS CIRCUMSTANTIAL WITNESS

RELATIONSHIP TO INJURED PERSON: _____

(If more than one witness, please provide details) _____

IF ANOTHER PARTY RESPONSIBLE, PLEASE PROVIDE DETAILS: _____

PART 3: PERSONAL INJURY DETAILS

PART OF BODY INJURED (Place tick in appropriate box)

Head & Neck	<input type="checkbox"/>	Hip	<input type="checkbox"/>	Hands/ Fingers	<input type="checkbox"/>
Eyes or Face	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	Knee	<input type="checkbox"/>
Back & Trunk	<input type="checkbox"/>	Arms / Wrists	<input type="checkbox"/>	Feet and toes	<input type="checkbox"/>

If Other, or multiple, please describe: _____

NATURE OF INJURY (Place tick in appropriate box)

Multiple	<input type="checkbox"/>	Minor Bruise - Not Disabling	<input type="checkbox"/>	Concussion/Unconscious (Serious)	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	Major Bruising - Disabling	<input type="checkbox"/>	Burns/Scalds – requiring medical attention	<input type="checkbox"/>
Sprain	<input type="checkbox"/>	Minor Cut/Laceration - No Stitches	<input type="checkbox"/>	Superficial	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	Cut/Laceration requiring Stitches	<input type="checkbox"/>	No Apparent Injury	<input type="checkbox"/>
Ligament Damage	<input type="checkbox"/>	Minor Concussion	<input type="checkbox"/>		

If Other, describe: _____

DESCRIPTION OF and SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT (as described by injured party)

DESCRIPTION OF INCIDENT (by you or independent witness)

WAS INJURED PERSON TAKEN TO: TREATMENT BY FIRST AIDER DOCTOR/HOSPITAL AMBULANCE

NAME OF FIRST AIDER/ PERSON ATTENDING: _____ CONTACT NO: _____

OTHER (Please describe): _____

IF THIRD PARTY/CONTRACTOR AT FAULT: THIRD PARTY/CONTRACTOR'S NAME: _____

THIRD PARTY/CONTRACTOR'S INSURANCE DETAILS _____

PART 4: PROPERTY DAMAGE (complete if there is property damage)

ITEM DAMAGED: _____

HOW DID DAMAGE OCCUR:

IF VIEWED AND BY WHOM: _____

PHOTOS TAKEN AND BY WHOM: _____

PART 5: LOCATION OF INCIDENT

PART 6: TYPE OF INCIDENT (Please tick in appropriate box)

Slip and Fall of Person:

- | | | |
|---|--|--|
| Chips <input type="checkbox"/> | Lack of Barrier <input type="checkbox"/> | Uneven Floor <input type="checkbox"/> |
| Ice Cream <input type="checkbox"/> | Rainwater on floor <input type="checkbox"/> | Tripped over Object <input type="checkbox"/> |
| Beverage <input type="checkbox"/> | Barrier/Signs <input type="checkbox"/> | Steps/Stairs <input type="checkbox"/> |
| Floor Slippery (Surface) <input type="checkbox"/> | Vegetable/Fruit items <input type="checkbox"/> | Car Park Stops/Bollards <input type="checkbox"/> |
| Inadequate Lighting <input type="checkbox"/> | Other Food <input type="checkbox"/> | No apparent Reason <input type="checkbox"/> |
| Person running <input type="checkbox"/> | Vomit <input type="checkbox"/> | |

If Other, describe: _____

Type of surface

- | | | | |
|-----------------------------------|---------------------------------|-----------------------------------|--|
| Marble <input type="checkbox"/> | Tile <input type="checkbox"/> | Carpet <input type="checkbox"/> | Speed hump <input type="checkbox"/> |
| Terrazzo <input type="checkbox"/> | Timber <input type="checkbox"/> | Bitumen <input type="checkbox"/> | Dirt/grass/garden <input type="checkbox"/> |
| Slate <input type="checkbox"/> | Vinyl <input type="checkbox"/> | Concrete <input type="checkbox"/> | Other <input type="checkbox"/> |

If Other, describe: _____

Other

Falling Objects If Falling objects, please describe: _____

Water Damage

WAS INJURED PERSON Reasonable Upset Aggressive Add relevant comments

RECORD OF INCIDENT Video/closed circuit Photo None