



Division of Labor Services

Chester J. Culver, Governor Patty Judge, Lt. Governor
 Dave Neil, Labor Commissioner

Office Use Only
Date Rec. _____
Time Rec. _____
Initials _____

Elevator, Boiler, and Amusement Ride Bureau
 1000 East Grand Avenue
 Des Moines, Iowa 50319-0209
 Ph#: 515-281-5415 or 515-281-3418 FAX: 515-242-5076

AMUSEMENT ACCIDENT REPORT

Ride Name	Operator's Name	Address of Incident
Ride Type (Thrill/Kiddie/Inflatable)	Operator's Address	Date/Time Incident Occurred
Permit #	City, State, Zip	Date Phone In/Time Phone In

Personal injuries and deaths. An operator shall report in writing to the commissioner an accident resulting in injury to any person within 48 hours after occurrence of the incident. The report of an accident shall include this completed form, along with a duplicate copy of the report submitted to insurance companies. The operator shall immediately report by telephone any accident in which a fatality occurs or a person suffers a fracture, concussion, laceration or other traumatic injury requiring immediate surgical or medical care. The commissioner, after consultation with the operator and determination, may require that the scene of such an accident be secured and not disturbed to any greater extent than necessary for removal of the deceased or injured persons. If a ride is removed from service by the commissioner, the commissioner shall order an immediate investigation and the ride or device shall be released for repair and operation only after complete investigation.

Describe fully how accident occurred and state what injured was doing when the accident occurred:

Are there any videotapes or photographs of the incident? Yes No (if yes, please mail copies)

Were safety orders issued at the last inspection? Yes No

Are repairs needed now? Yes No (Detail Repairs Needed)

Does Operator have a Permit Yes No

Date of Last Inspection:

Has ride been secured from operation? Yes No If no, why?

Operator Notified: Yes No
 If Yes, Contact(s) and Telephone Number(s)

WITNESS(ES)			
Name	Address	Phone #	Approx. Age
Name of 1st injured:		Age:	Date of injury: Time of injury:
Address:			
City:		State:	Telephone:
Were injuries to this person fatal? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury to this person require hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did injury to this person require first aid? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Nature of injury:			
Name of 2nd injured:		Age:	Date of injury: Time of injury:
Address:			
City:		State:	Telephone:
Were injuries to this person fatal? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury to this person require hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did injury to this person require first aid? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Nature of injury:			
Name of 3rd injured:		Age:	Date of injury: Time of injury:
Address:			
City:		State:	Telephone:
Were injuries to this person fatal? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury to this person require hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did injury to this person require first aid? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Nature of injury:			

I hereby certify pursuant to the laws of the State of Iowa that the above information is true and correct to the best of my knowledge and belief.

Name of Person Filing Report (Please Print Clearly)	Company or Firm
Signature of Person Filing Report	Date of this Report

For Office Use Only

Acquired Written Report from First Responder (if applicable) Acquired Hospital Report (if applicable)
 Report Filed Immediately w/ Division of Labor Services