Iowa Division of Labor
Amusement Ride Safety
150 Des Moines Street
Des Moines, IA 50309-1836
Phone: 515-725-5612/515-725-5608
Fax: 515-242-5076
amusement@iwd.iowa.gov
amusement.iowa.gov

FOR OFFICE USE ONLY

Received date:_____ Time:_____

Notified date:_____ Time:_____

Filed on time: ☐ Yes ☐ No

First responder written report: ☐ Yes ☐ No

Hospital report: ☐ Yes ☐ No

Initials:_____

Amusement Accident Report

The operator shall immediately report by phone a fatality or an accident that requires medical care more than first aid. An operator shall report in writing to the Labor Commissioner an accident resulting in injury within 48 hours after occurrence of the incident. The report of an accident shall include this completed form and a copy of the report submitted to insurance companies. The Labor Commissioner may require that the scene of an accident be secured and not disturbed more than necessary for removal of deceased or injured persons. If covered equipment is removed from service by the Labor Commissioner, the Labor Commissioner shall order an immediate investigation and the covered equipment shall be released for repair and operation only after a complete investigation.
The covered equipment may not be returned to service until it successfully passed a complete inspection.

Ride name	Ride type (thrill/inflatable/kiddie)	ID#	Accident date/time	
Address of incident	Operator's name		Phone number	
Operator's address	City		State	Zip
Describe in detail what happened:				

Number of people injured: 12	Are there videotapes or photographs of the incident? ☐ **Yes** ☐ **No** (If yes, send copies)
Were safety orders issued at the last inspection? ☐ **Yes** ☐ **No**	Date of last inspection: 12
Does the operator have a permit to operate? ☐ **Yes** ☐ **No**	Are repairs needed now? ☐ **Yes** ☐ **No** (If yes, attach details of repairs needed)
Has ride been secured from operation? ☐ **Yes** ☐ **No** If no, why? 12	
Has operator been notified? ☐ **Yes** ☐ **No** If yes, name/phone number: 12	

Amusement Accident Report

Witnesses

Name	Address	Phone number	Age
Name	Address	Phone number	Age
Name	Address	Phone number	Age
Name	Address	Phone number	Age

People Injured

1. Name		Age	Phone number	
Address	City		State	Zip
Email address	If minor, parent/guardian name		Phone number	
Injuries: Fatal? ☐ **Yes** ☐ **No**	Require hospitalization? ☐ **Yes** ☐ **No**		Require first aid? ☐ **Yes** ☐ **No**	
Nature of injury:				

2. Name		Age	Phone number	
Address	City		State	Zip
Email address	If minor, parent/guardian name		Phone number	
Injuries: Fatal? ☐ **Yes** ☐ **No**	Require hospitalization? ☐ **Yes** ☐ **No**		Require first aid? ☐ **Yes** ☐ **No**	
Nature of injury:				

3. Name		Age	Phone number	
Address	City		State	Zip
Email address	If minor, parent/guardian name		Phone number	
Injuries: Fatal? ☐ **Yes** ☐ **No**	Require hospitalization? ☐ **Yes** ☐ **No**		Require first aid? ☐ **Yes** ☐ **No**	
Nature of injury:				

I certify that the information on this form and attachments (if any) is true and accurate to the best of my knowledge.

Name of Person Filing Report **Phone Number** **Company or Firm Name** **Signature** **Date**

Please complete a set of questions for each injured person, if number of injured is more than 3 an additional injured report can be found at amusement.iowa.gov under Quick Links.