Iowa Division of Labor
Elevator Safety
Mailing address: 1000 East Grand Avenue, Des Moines, IA 50319-0209
Physical address: 150 Des Moines Street, Des Moines, IA 50309 (FedEx/UPS)
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elevators@iwd.iowa.gov
www.iowaelevators.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:__________

Conveyance Accident Report

The owner or duly authorized agent shall immediately notify the Labor Commissioner of each and every personal injury accident requiring the care of a physician, or causing disability exceeding one day, or causing damage to the conveyance exceeding $2,000.00. Notification shall be in writing, shall specifically identify the conveyance, state identification number, owner and description of accident. When a personal injury involves the failure or destruction of any part of the conveyance or the operating mechanism of a device, the use of the device is forbidden until it has been made safe and has been re-inspected. Any repairs or alterations shall be approved by the Labor Commissioner. The removal of any part of the damaged conveyance or operating mechanism from the premises is forbidden, until permission to do so has been granted by the Labor Commissioner.

Owner's name	Owner's ID	State ID	Manufacturer	Accident date/time

Accident building address	City	State	Zip
Owner's address	**City**	**State**	**Zip**

Phone number	Fax number	Email address

Type of conveyance: Escalator Elevator Special purpose Other:

Describe in detail what happened:

Number of people injured:	Are there videotapes or photographs of the incident? **Yes** **No** (If yes, send copies)
Were safety orders issued at the last inspection? **Yes** **No**	Are repairs needed now? **Yes** **No** (If yes, attach details of repairs needed)
Does the conveyance have a permit to operate? **Yes** **No**	Date of last inspection:

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

Has conveyance contractor been notified? **Yes** **No** If yes, name/phone number:

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.
For deaf and hard of hearing, use Relay 711.

Conveyance 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 www.iowaelevators.gov under Quick Links.