IOWA WORKFORCE DEVELOPMENT
Smart. Results.

Division of Labor Services

| 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? ☐ Yes ☐ No | Did injury to this person require hospitalization? ☐ Yes ☐ No

Did injury to this person require first aid? ☐ Yes ☐ 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? ☐ Yes ☐ No | Did injury to this person require hospitalization? ☐ Yes ☐ No

Did injury to this person require first aid? ☐ Yes ☐ 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? ☐ Yes ☐ No | Did injury to this person require hospitalization? ☐ Yes ☐ No

Did injury to this person require first aid? ☐ Yes ☐ 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 ☐