

**Iowa Division of Labor
Amusement Ride Safety**

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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:	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:			
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?				
Has operator been notified? Yes No If yes, name/phone number:				

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
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