CUSTOMER ACCIDENT/INCIDENT REPORT
Instruction: This form must be completed by the store manager whenever an accident/incident occurs. The assistant manager or authorized designate for the store will be responsible for completing this form in the absence of the store manager. The store manager must ensure a copy of the completed report is forwarded to the Human Resources Manager.

Date of Report: ____________________________________________

Store Location:________________________________________________

Date of Accident: ______________ Exact Time of Accident: ______ A.M./P.M.

Name of Manager on duty at time of accident: _____________________________

Name of Store Employee who completed this report: _________________________

1. Did you witness accident/incident? Yes No
2. If not, who informed you of the accident?

_____________________________________________________________________

Outside weather conditions: (circle all that apply): Clear, Cloudy, Raining, Snowing, Windy, Light, Dark
Other ___________________________________________________________________

_____________________________________________________________________

Exact location of accident/incident at store

Description of Accident or Incident:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Did you inspect location immediately after accident/incident? Yes No
Exact Time of inspection: ____________ Number of photographs taken of location:

_____________________________________________________________________

Was location clean? Yes No Dry? Yes No
Any signs Posted?
When was the last time the area was cleaned? __________ By whom?

_____________________________________________________________________

When was the last time the area was checked? __________ By whom?

_____________________________________________________________________

Describe lighting conditions:
_____________________________________________________________________
_____________________________________________________________________
INJURED PERSON INFORMATION

Name of person injured:
________________________________________________________________________

Home Address:
________________________________________________________________________
________________________________________________________________________

Home Phone #: ______________________________

Work Phone #: __________________________

Age or Date of Birth: ______________________
Was injured person wearing glasses?
________________________________________

Type of footwear injured person was wearing:
________________________________________

Describe Injury:
________________________________________________________________________

Describe medical care at scene (if any) & name of doctor, hospital or clinic:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Name of injured person’s companion, if any:
________________________________________

Address:
________________________________________________________________________

Home Phone #: ______________________________

Witnesses, if any:
Name: ____________________________ Name: ____________________________
Address: ____________________________ Address: ____________________________
Phone #: ____________________________ Phone #: ____________________________

Signed by Supervisor: ___________________ Supervisor’s Name: __________________

Signed by Person Involved: _______________ Signed by HR: ______________________

Signed by Store Manager: _________________ Date: ____________________________