

Chester J. Culver, Governor Patty Judge, Lt. Governor
Dave Neil, Labor Commissioner

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

CONVEYANCE ACCIDENT REPORT

Building Name	Owner's Name	Owner's ID
Building Street Address	Owner's Address	State ID
City, State, Zip	City, State, Zip	Manufacturer

875—71.3(89A) Accident Reports - The owner or duly authorized agent shall immediately notify the commissioner of each and every personal injury accident requiring the service of a physician or causing disability exceeding one day or causing damage to the conveyance exceeding \$2,000. Notification shall be in writing, and shall specifically identify the conveyance, state identification number, owner, and description of accident. When an accident 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 until it has been reinspected and any repairs or alterations have been approved by the 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 commissioner.

Type of Conveyance

Escalator Elevator Special Purpose Other _____

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 the conveyance have a Permit to Operate? Yes No

Date of Last Inspection:

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

Conveyance Contractor Notified: Yes No
If Yes, Company Contact(s) and Telephone Number(s)

WITNESS(ES)			
Name	Address	Phone #	Approx. Age
Number of people injured:			
Please complete a set of questions for each injured person			
Name of 1st injured:		Age:	Date of injury: Time of injury:
Address:			
City:		State:	Telephone:
Were injuries to this person fatal <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury to this person require hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did injury to this person require first aid? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury to this person require hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did injury to this person require first aid? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury to this person require hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did injury to this person require first aid? <input type="checkbox"/> Yes <input type="checkbox"/> 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