Address to:
( ) Jusfing Company
( ) Legal Dept., Int'l. Hdqrs.
( )

Date of Accident
Day of Week
Hour A.M. P.M.

3Z:1

INJURED PERSON

Name (If child, also secure parent's name) Address STREET CITY STATE

Married ( ) Single ( )
Occupation
Employer
Employer's Address

Phone Number
Approximate Age
Approximate Weight
Approximate Height
Was injured wearing glasses?

TYPE OF ACCIDENT make an X in one of the following boxes:
- ☐ slip and fall or other accident inside the store or store entry
- ☐ parking lot fall or other accident outside store
- ☐ caused by merchandise or food - - - give complete details on reverse
- ☐ automotive service work
- ☒ other (describe in detail)

ANSWER ALL QUESTIONS

Customer's Version of How Accident Happened.

Injury

What injury to person or clothing did you observe?

Describe first aid rendered

Who rendered first aid?

If referred to doctor, give name and address
(See that doctor understands he is to render first aid only and send Authorization for First Aid form with customer)

If customer said would seek own treatment give name and adress where treatment would be sought

Did customer indicate further action expected of us? ☐ yes ☐ no.

If yes, what is expected?

Persons who saw or know about Accident - List every one - Attach their statements

(a) Persons (Not Employees) who saw or know about Accident.

(Name) (Address)

(b) Employees who saw Accident.

(Name) (Home Address)

(c) Employees who did not see Accident but arrived at scene shortly after.

(Name) (Home Address)

(SEE REVERSE SIDE)

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