



# ASR

Underwriting  
Agencies

Coverholder at **LLOYD'S**

TO BE COMPLETED IN THE EVENT OF INJURY OR PROPERTY DAMAGE  
AND FAX TO 07 3807 6839 OR EMAIL TO [claims@asruw.com.au](mailto:claims@asruw.com.au)

## INCIDENT REPORT FORM

### REPORT DETAILS

Insured					
Policy number					
Date reported		Time reported			
Exact location					
Date of incident		Time of incident		Day of week	
Incident report completed by					
Incident reported to					
Time incident location inspected		Inspected by			

### PART 1: Injured persons details

Full name					
Address					
Home phone		Business phone		Mobile phone	
Date of birth		(Approximate age if date of birth not known)	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
	<input type="checkbox"/> Walking stick	<input type="checkbox"/> Glasses	<input type="checkbox"/> Carrying goods	<input type="checkbox"/> Intoxicated	<input type="checkbox"/> Other impairments

### PART 2: Witness\* details

\* Eyewitnesses who witnessed the incident; circumstantial witnesses who witnessed the events leading up to or following the incident. Provide additional witness details on attachment.

Full name					
Address					
Home phone		Business phone		Mobile phone	
Witness type	<input type="checkbox"/> Eye witness <input type="checkbox"/> Circumstantial witness				
Relationship to injured person					
If more than one witness, please provide details:					
If any other party responsible, please provide details:					

### PART 3: Personal injury details

#### Part of the body injured

<input type="checkbox"/> Head & neck	<input type="checkbox"/> Back & trunk	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hands / fingers	<input type="checkbox"/> Feet & toes	<input type="checkbox"/> Eyes or face
<input type="checkbox"/> Hip	<input type="checkbox"/> Arms / wrists	<input type="checkbox"/> Knee	<input type="checkbox"/> Other or multiple (please describe)		

### PART 3: Personal injury details

#### Nature of injury

<input type="checkbox"/> Multiple	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Major bruising (disabling)	<input type="checkbox"/> Minor concussion
<input type="checkbox"/> Fracture	<input type="checkbox"/> Ligament damage	<input type="checkbox"/> Minor cut/laceration (no stitches)	<input type="checkbox"/> Concussion/unconscious (serious)
<input type="checkbox"/> Sprain	<input type="checkbox"/> Minor bruise (not disabling)	<input type="checkbox"/> Cut/laceration (requiring stitches)	<input type="checkbox"/> Superficial
<input type="checkbox"/> No apparent injury		<input type="checkbox"/> Other (please describe)	

**Description of and sequence of events** leading up to the incident (as described by injured party)

**Description of incident** (by you or independent witness including an un-biased view on whether the injured person contributed to the injury)

Was injured person taken to: ☐ Treatment by first aider ☐ Doctor/hospital ☐ Ambulance

Name of first aider attending Contact phone

#### If third party/contractor at fault:

Third party/contractor name

Third party/contractor insurance details

### PART 4: Property damage (complete if there is property damage)

Item damaged

Details

If viewed and by whom

Photos taken and by whom

### PART 5: Location of incident (please tick appropriate box)

<input type="checkbox"/> Car park	<input type="checkbox"/> Food areas	<input type="checkbox"/> Internal ramp	<input type="checkbox"/> Stairs	<input type="checkbox"/> Restaurants
<input type="checkbox"/> Car park ramps	<input type="checkbox"/> Dance floor	<input type="checkbox"/> Children's play area	<input type="checkbox"/> Escalators	<input type="checkbox"/> Gaming areas
<input type="checkbox"/> Bar	<input type="checkbox"/> Entrance/exit	<input type="checkbox"/> Balcony	<input type="checkbox"/> Elevators	<input type="checkbox"/> Toilet areas
<input type="checkbox"/> Office areas	<input type="checkbox"/> Other (please describe)			

### PART 6: Type of incident (please tick appropriate box)

#### Slip and fall of person cause

<input type="checkbox"/> Chips	<input type="checkbox"/> Other food	<input type="checkbox"/> Person running	<input type="checkbox"/> Uneven floor	<input type="checkbox"/> Car park stops/bollards
<input type="checkbox"/> Ice cream	<input type="checkbox"/> Vomit	<input type="checkbox"/> Lack of barrier	<input type="checkbox"/> Tripped over object	<input type="checkbox"/> No apparent reason
<input type="checkbox"/> Beverage	<input type="checkbox"/> Slippery floor surface	<input type="checkbox"/> Rainwater on floor	<input type="checkbox"/> Steps/stairs	<input type="checkbox"/> Inadequate lighting
<input type="checkbox"/> Fruit/vegetables	<input type="checkbox"/> Barrier/signs	<input type="checkbox"/> Other (please describe)		

#### Other

☐ Falling objects (please describe) ☐ Water damage

#### Type of surface

<input type="checkbox"/> Marble	<input type="checkbox"/> Tile	<input type="checkbox"/> Carpet	<input type="checkbox"/> Speed hump	<input type="checkbox"/> Terrazzo
<input type="checkbox"/> Timber	<input type="checkbox"/> Bitumen	<input type="checkbox"/> Dirt/grass/garden	<input type="checkbox"/> Slate	<input type="checkbox"/> Vinyl
<input type="checkbox"/> Concrete	<input type="checkbox"/> Other (please describe)			

Was the injured person	<input type="checkbox"/> Reasonable	<input type="checkbox"/> Upset	<input type="checkbox"/> Aggressive	
Relevant comments:				
Cleaner on duty (please attach a written statement from cleaner if appropriate)				
Name of cleaner on duty			Cleaning supervisor	
Time location last inspected		Time location last cleaned		
Record of incident	<input type="checkbox"/> Video/closed circuit	<input type="checkbox"/> Photo	<input type="checkbox"/> None	

PRINT FORM

RESET FORM