CDA
CLAIMS DIRECT ACCESS

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After Hours Claim Reporting: 877-243-8182
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INCIDENT/ACCIDENT REPORTING FORM

General Information

Name of Insured: _____

Contact Name: _____

Insured's Address: _____

City: _____ State _____ Zip: _____

Phone number: ( ) _____ Best time to contact: _____

Policy Number: _____ **Effective Date of Policy:** _____

Description of Injured Party

Name of Injured Party: _____

If a minor, legal guardian's name: _____

Address: _____

_____

Employer: _____

Home Phone: ( ) _____ Business Phone: ( ) _____

Description of Accident

Date of Injury: _____ Time of Injury: _____

Activity Participating In: _____

Describe in detail how the accident happened (use reverse if necessary): _____

_____

_____

Describe the injured's mental status at the time of the accident:

☐ Confused ☐ Calm ☐ Panicked ☐ Aggressive ☐ Other: _____

Describe Evacuation: _____

_____

_____

Describe location of the site where the accident occurred: _____

_____

_____

Describe the weather: _____

Temperature (estimate if necessary): _____ degrees Fahrenheit

Did equipment contribute in any way to the accident? ☐ Yes ☐ No

If yes, please describe: _____

Did the injured party contribute to the accident in any way? ☐ Yes ☐ No

If yes, please describe: _____

Did the injured party state that he or she contributed to the accident in any way? ☐ Yes ☐ No

If yes, please describe: _____

Did another participant contribute to the injury? ☐ Yes ☐ No

If yes, please describe: _____

Were any photographs taken? ☐ Yes ☐ No

If yes, please enclose all photographs.

Activity Time Lost: ☐ None ☐ ½ Day or More ☐ Ended Participation

Describe any first aid given (include a list of any medications given): _____

_____

_____

Did the injured party refuse first aid or evacuation? ☐ Yes ☐ No

If yes, please describe: _____

Does the injured take any medications or have any allergies? ☐ Yes ☐ No

If yes, please describe: _____

Is this a re-injury of an old condition? ☐ Yes ☐ No

Employees on site at time of accident:

Name	Age	Experience
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the injured party been at this location before? ☐ Yes ☐ No

If yes, indicate frequency: _____

Does the injured party currently have medical insurance? ☐ Yes ☐ No

If yes, with what company?: _____

Signature: _____ Title: _____

Print Name: _____ Date: _____