Accident Detail Summary

Date of Incident: _____ Time of Incident: _____

Injured Person's Name: _____

Name of Witness: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Mailing Address: _____ _____

Location of Accident (address): _____

Area (loading dock, bathroom): _____

Describe fully how the accident occurred to the best of your knowledge (including events that occurred immediately before the incident):

_____

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body parts(s) affected): _____

_____

_____

List any additional witnesses present at the time of the accident: _____

_____

_____

Completed By: _____ Date: _____

Please return this completed form to:
DCClaims@douglasnv.us
Fax: 775-782-9083

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