DISTILLERY
ACCIDENT/INCIDENT INFORMATION FORM

INJURED PERSON:	REPORTED BY:
Full Name:	Name:
Address:	Address:
Home Phone:	Phone:
Cell Phone:	Cell Phone:
e-mail:	e-mail:

DATE & TIME OF ACCIDENT	DATE & TIME REPORTED
Date: _____ /_____ /_____	Date: _____ /_____ /_____
Time: _____ ☐ AM ☐ PM	Time: _____ ☐ AM ☐ PM
Location of Accident/Injury:	

INCIDENT TYPE: (Check All That Applies)

☐ Personal Injury/Illness ☐ Vehicle Accident ☐ Property Damage ☐ Work Related ☐ Other

WHAT HAPPENED TO THE INJURED PARTY:

☐ First Aid Administered ☐ Refused Treatment/Transport ☐ Left With Friend ☐ Transported to Hospital
☐ Returned to Work ☐ Went Home ☐ Went to Physician ☐ Unknown

PERSONAL INJURY/ILLNESS	
Cause of Injury:	Part(s) of Body Injured:
Witness Name(s):	Contact Info:
WAS INJURY A RESULT OF THE USE A MOTOR VEHICLE: ☐ YES ☐ NO (If yes, complete Auto Section)	

VEHICLE ACCIDENT	
DRIVER 1 - VEHICLE INFORMATION	**DRIVER 2 - VEHICLE INFORMATION**
Driver Name:	Driver Name:
Driver's License Number:	Driver's License Number:
DOB: _____ /_____ /_____ State:	DOB: _____ /_____ /_____ State:
License Plate Number:	License Plate Number:
Make: Model: Year: Color:	Make: Model: Year: Color:
Owner:	Owner:

PROPERTY DAMAGE	
Cause of Damage:	
Witness Name(s):	Contact Info:

I hereby certify that the above information is true and correct to my understanding of this incident.

Print Name	Signature	Date

** Return Completed Form to an owner within 12 hours.*