GUEST INCIDENT REPORT

LOCATION OF ACCIDENT:

STORE CODE: ( ) STORE NAME: _____ PHONE #: ( )_____

STORE ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF OCCURRENCE: _____ TIME: _____ ☐ AM ☐ PM

Was medical treatment provided? ____Yes ____ No By whom? _____

Was the ambulance called? _____ Yes ____ No Was the injured party taken to the hospital? _____ Yes ____ No

Name of Hospital: _____ Address: _____

INJURED PARTY INFORMATION:

NAME: _____ AGE: _____ SEX: ☐ MALE ☐ FEMALE

ADDRESS: _____ PHONE #: ( )_____

EMPLOYER'S NAME: _____ PHONE #: ( )_____

ADDRESS: _____

DESCRIBE HOW THE INCIDENT HAPPENED: _____

_____

_____

_____

DESCRIBE THE INJURY: _____

_____

Wet Floor signs posted? : _____ Yes _____ No How Many?: _____

Where were they located? : _____

Was there a foreign object? : ___Yes ___No Who obtained the foreign object? ☐ Claimant ☐ Store Mgr ☐ Cust. Relations

Was the customer refunded for their meal? _____Yes ____ No Was the meal replaced?_____ Yes _____ No

REMARKS: _____

_____

GENERAL MANAGER'S NAME: _____ ☐ ON DUTY ☐ OFF DUTY

DISTRICT'S MANAGER'S NAME: _____

PERSON IN CHARGE: _____

CASHIER: _____

KITCHEN CREW: _____

WITNESSES:

NAME: _____ PHONE #: ( )_____

NAME: _____ PHONE #: ( )_____

NAME: _____ PHONE #: ( )_____

REPORTED BY: _____

TITLE: _____ **DATE:** _____

File Name: Guest Incident Report