PERSONAL INJURY ACCIDENT REPORT

(To be completed by Injured party in complete detail)

YOUR NAME:. _____

LOCAL/HOTEL ADDRESS: _____ PHONE: _____

HOME ADDRESS: _____ PHONE: _____

OCCUPATION/POSITION: _____ BUS PHONE: _____

YOUR DATE OF BIRTH: _____ SOCIAL SECURITY NO.: _____

DATE/TIME OF ACCIDENT: _____

WHERE DID THE ACCIDENT HAPPEN (Please be specific) _____

_____

_____

PLEASE GIVE A DETAILED DESCRIPTION OF THE ACCIDENT (Use back of page if necessary)

_____

_____

_____

DID ANYONE ELSE WITNESS THE ACCIDENT? YES ☐NO ☐ IF SO, WHO?

NAME/ADDRESS _____ PHONE: _____

NAME/ADDRESS _____ PHONE: _____

NAME/ADDRESS _____ PHONE: _____

WHAT WERE YOU DOING WHENTHE ACCIDENT HAPPENED? _____

_____

_____

WAS ANY FOOD OR DRINK INGESTED? _____

YES ☐ NO ☐ IF SO, WHAT TYPE OF FOOD OR DRINK WAS INVOLVED? _____

_____

WAS FIRST AID ADMINISTERED? YES ☐ NO ☐ IF SO, WHO PROVIDED ITAND WHAT WAS PROVIDED?

_____

NAME AND ADDRESS OF YOUR FAMILY DOCTOR_____

_____

NAME AND ADDRESS OF DOCTOR WHO TREATED YOU FOR THIS INJURY/ILLNESS _____

_____

SIGNATURE:_____DATE:_____

(Use back of page if necessary)

SEND TO:

Kainoa Scheer **kscheer@acwhawaii.com**
ACW Group, LLC
Insurance, Bonding & Employer Solutions
1000 Bishop Street, Suite 600 |Honolulu, Hawaii 96813
Tel: (808) 535-5076 | Fax: (808) 535-5055 | Mobile: (808) 392-2056 | www.acwgroup.com

Copy: Keri Mehling (kerionmaui@yahoo.com)

PERSONAL INJURY WITNESS REPORT

(To be completed by Witness to Injury)

NAME OF WITNESS: _____ (Check one) Passenger ☐ Crew ☐

NAME OF PERSON INJURED: _____VESSEL: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

EXACT LOCATION WHERE ACCIDENT OCCURRED: _____

PLEASE GIVE A DETAILED DESCRIPTION OF THE ACCIDENT (use back of page if necessary)

_____

_____

_____

WEATHER & SEA CONDITIONS: _____

_____

_____

WHAT WERE YOU DOING AT THE TIME OF THE ACCIDENT? _____

_____

HOW FAR WERE YOU FROM THE INJURED PERSON? _____

GIVE IDENTITY OF ANY OTHER WITNESSES:

NAME/ADDRESS: _____ PHONE:_____

NAME/ADDRESS: _____ PHONE:_____

NAME/ADDRESS: _____ PHONE:_____

WAS FIRST AID ADMINISTERED? YES ☐ NO ☐ IF SO, WHO PROVIDED IT? _____

PLEASE DESCRIBE THE TYPE OF INJURY SUSTAINED? _____

_____

WAS THE INJURED PERSON TAKEN TO A PHYSICIAN OR HOSPITAL? YES ☐ NO ☐

NAME/ADDRESS OF PHYSICIAN OR HOSPITAL: _____

_____

ADDITIONAL INFORMATION REGARDING THE ACCIDENT? _____

_____

SIGNATURE OF WITNESS: _____ DATE: _____

HOME ADDRESS: _____ HOME PH.: _____

LOCAL HOTEL/ADDRESS: _____ LOCAL PH.: _____

EMPLOYMENT POSITION: _____ NO. OF YEARS: _____

WORK ADDRESS: _____ WORK PH.: _____

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