

Michigan Department of Licensing and Regulatory Affairs
 Bureau of Commercial Services
 SKI-AMUSEMENT SAFETY
 P.O. Box 30018, Lansing, MI 48909
 Telephone: 517-241-9273
 Fax: 517-241-9280
 www.michigan.gov/amusement

PERSONAL INJURY REPORT - AMUSEMENT DEVICE

AUTHORITY: P.A. 225 of 1966, as amended
 COMPLETION: Mandatory; see "Instructions" below
 PENALTY: Failure to complete may result in suspension of permit to operate

INSTRUCTIONS: Within 24 hours of the occurrence, report to the Department all ride-related injuries that require treatment by medical professionals. Report deaths and serious injuries immediately. Submit written report within seven (7) days. Other minor injuries are to be recorded in a first aid log, but do not need to be reported. Reference: PA 225 of 1966 408.734 Rule 43, ASTM F 1305 - 02 sections 2.1, 4.1 and 5.1.3.

CARNIVAL/AMUSEMENT COMPANY INFORMATION:			
Name of Company			Date of Incident/Injury
Permanent Address (Number, Street, City, State, Zip Code)			Telephone Number ()
Name of Ride			Ride I.D. Number 20050-
Name of Ride Operator		Location of Incident (City/Town/Event)	
Name of Insurance Company			
INJURY INFORMATION:			
Number of Employees Injured		Number of Patrons Injured	Degree of Injury (Ref., ASTM F 1305-02 2.1)
Extent of Injuries <input type="checkbox"/> Lacerations <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Broken Bone(s) <input type="checkbox"/> Other:		<input type="checkbox"/> Minor <input type="checkbox"/> Serious	Location of Incident (Ref., ASTM F 1305-02 5.1.3) <input type="checkbox"/> On Ride <input type="checkbox"/> Other <input type="checkbox"/> Loading and Unloading
Brief description of incident and cause			
What has been done to prevent recurrence of the incident?			
INJURED PERSON'S INFORMATION (Document additional injured person's information on Page 2.)			
Injured Person's Name			Age (years) Height (inches) Weight (lb)
Injured Person's Address (Number, Street, City, State, Zip Code)			
Telephone Number	Date of Birth	Check One <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
Injured person transported to medical facility by: <input type="checkbox"/> Ambulance <input type="checkbox"/> Personal Vehicle <input type="checkbox"/> Not Transported <input type="checkbox"/> First Aid at site <input type="checkbox"/> Other:			Medical facility: (Hospital, Clinic, etc.)
Signature and Title of Person Preparing Report			Date of Signature

