

Customer Accident



Customer Injury

When a customer injury has occurred, follow these steps.

1. Complete the [Customer Injury Report](#).
2. Complete the [Medical Release of Information Authorization](#) form on back of [Customer Injury Report](#).
3. Complete [Information for Insurance Company](#).
4. Have all witnesses and employees present complete [Customer Injury Witness Statement](#).
5. See that customer gets appropriate medical attention (first aid, medical clinic, emergency room, etc.)
6. Report customer injury to Manager immediately.
7. Take pictures of the accident site.
8. Scan and email all documents immediately to marsha.parker@smithdq.com. Mail all originals to home office within 24 hours of the injury.

Customer Injury Report

Smith Dairy Queen Store: _____ Manager: _____
Address: _____ City, State: _____

Injured

Name: _____ Age: _____ Sex: _____
Address: _____ City, State: _____

Home #: () _____ Cell #: () _____ TDL: _____

Employed by: _____
Address: _____ City, State: _____

Title/Occupation: _____ Work #: () _____

Person to Notify (if child, list parent/guardian): _____ Phone #: () _____

Accident Facts

Date: _____ Time: _____ am/pm

Location of Accident: (Circle)
Parking Lot Restroom Dining Room Drive Through Other: _____

What was customer doing at time of accident: _____

Physical description of injured: _____

Medical Treatment (Circle)
First Aid Physician Ambulance Hospital Body part affected: _____

Type of First Aid administered: _____

Medical facility contacted? Yes/ No Date: _____ Time: _____

Method of transportation: _____

Name, Address, Phone # of driver: _____
List name, address, phone # for medical services below:
Physician: _____
Hospital: _____
Ambulance: _____

Statement of Injured: _____

Signature of Customer/Injured _____ Printed Name _____ Date _____

Signature of Manager/Supervisor _____ Printed Name _____ Date _____

Customer Injury Witness Statement

Fax Completed form to Smith Dairy Queens, LTD at 979-846-8618.

Name of Witness _____ Phone _____
Home Address _____ City _____ State _____ Zip _____
Relationship to Injured (if applicable): _____
If no relation, reason in store/witnessed incident: _____

Accident Facts

This statement concerns my knowledge of the alleged incident.

Name of Injured _____

Date of Incident _____ Time of Incident _____ am/pm Dairy Queen Location _____

Please explain in detail what you know about this incident: (Name specific individuals, objects, or equipment)

Did you actually see the incident? _____ If not, how did you hear about it? _____

Do you know of any other injury, incident or illness that this person has had? _____ If so, explain _____

Additional Information _____

I CERTIFY that the foregoing statements and answers on this form are complete and true, and that no information has been omitted.

Witness: _____

Signature

Date: _____

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

Information for Insurance Company

Fax completed form to Smith Dairy Queens LTD at 979-846-8618.

To be completed by Store Manager or District Supervisor

Name _____	Store Location _____
Job Title / Position _____	Telephone Number: _____

1. Please explain in detail how the incident occurred:

2. Please e-mail a photo of the fall area to: marsha.parker@smithdq.com

3. Was the area defective or hazardous in any way? Please explain your answer as to why or why not.

4. Do you believe Smith DQ to be negligent in any way in causing this incident? Explain your answer either way.

5. Is Smith DQ responsible for maintenance and repair of this area? Please circle one: Yes / No

6. Any surveillance video of the fall? Please circle one: Yes / No

7. If any employees witnessed the incident, please have them provide a statement explaining what they witnessed.

8. Do you happen to know the weather on that day? _____

9. Describe claimant (customer) to us. Approximate age, height, weight, any limp or using a cane or walker etc.?

10. Forward any (customer) incident report completed.

I CERTIFY that the foregoing statements and answers are complete, true and that no information has been omitted.

Signature: _____

Date: _____

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