A close up of a logo

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**Incident Report Form**

**Nexo Insurance Services, Inc.**

**License No. OE14627 • Phone: (310) 937-2007**

**Submit completed report to** [**info@nexoins.com**](mailto:info@nexoins.com) **or fax to (310) 937-1127.**

**Basic Information**

|  |  |
| --- | --- |
| **Company name** |  |
| **DBA** |  |
| **Person completing/submitting this form:** | |
| **Name** |  |
| **Position/Title** |  |
| **Phone number(s)** |  |
| **Email address(es)** |  |

**Incident Information**

|  |  |
| --- | --- |
| **Date of incident** |  |
| **Time of incident** | **AM  PM** |
| Mark all that apply. | **Before class  During class  After class  During open gym** |
| **Location of incident** |  |
| Mark all that apply. | **Inside class space  Outside/Parking lot  Restroom  Common Area** |
| **Body part(s) injured** | **Ankle  Knee  Leg  Foot  Toe  Arm  Hand**  **Shoulder  Wrist  Finger  Eye  Ear  Nose  Head  Tooth  Back  Neck  Internal  Other  No injury** |
| **Type of injury** | **Abrasion  Burn  Cardiac Arrest  Cold injury  Concussion**  **Contusion  Dislocation  Foreign body  Fracture**  **Heat exhaustion  Laceration  Nausea  Pain**  **Rhabdomyolysis  Seizure  Sprain  Sting/Bite  Strain  Stroke** |
| **Cause of injury** | **Collision  Struck by object  Animal/Insect bite/sting**  **Slip/Fall  Assault/Sexual assault  Property damage** |
| **Outcome** | **No care given:**  Not needed  Patient refused  **Released:**  To spouse/friend  To self  **Referred:**  To doctor  To hospital/clinic  **EMS Transported:**  Patient/Spouse requested |
| **Police report filed** | **Yes  No** |
| Police report number |  |
| Officer’s name |  |
| Officer’s contact information |  |
| **Describe how the incident, injury or property damage occurred in full detail.** |  |

**Affected Party**

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Phone number(s)** |  |
| **Email address(es)** |  |
| **Birth date** |  |
| **Relationship to affiliate** | **Owner  Staff  Member  Drop-in  Spectator**  **Non-athletic participant visitor** |
| **Does the injured party have health insurance?** | **Yes  No** |
| Name of health insurance provider |  |
| Policy number |  |
| Employer name |  |
| Employer address |  |

**Witness Information**

**If possible, gather and attach witnesses’ written statements.**

|  |  |  |
| --- | --- | --- |
| **Name** | **Address** | **Phone number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please note any other comments relevant to the circumstances of the incident below.**

|  |
| --- |
|  |

**Signature**

**Date**