

**Office Use Only**

Date Rec. \_\_\_\_\_

Time Rec. \_\_\_\_\_

Initials \_\_\_\_\_

Elevator, Boiler, and Amusement Ride Bureau  
 1000 East Grand Avenue  
 Des Moines, Iowa 50319-0209  
 Ph#: 515-281-5415 or 515-281-3418 FAX: 515-242-5076

## CONVEYANCE ACCIDENT REPORT

<b>Building Name</b>	<b>Owner's Name</b>	<b>Owner's ID</b>
<b>Building Street Address</b>	<b>Owner's Address</b>	<b>State ID</b>
<b>City, State, Zip</b>	<b>City, State, Zip</b>	<b>Manufacturer</b>

**875—71.3(89A) Accident Reports** - The owner or duly authorized agent shall immediately notify the commissioner of each and every personal injury accident requiring the service of a physician or causing disability exceeding one day or causing damage to the conveyance exceeding \$2,000. Notification shall be in writing, and shall specifically identify the conveyance, state identification number, owner, and description of accident. When an accident involves the failure or destruction of any part of the conveyance or the operating mechanism of a device, the use of the device is forbidden until it has been made safe and until it has been reinspected and any repairs or alterations have been approved by the commissioner. The removal of any part of the damaged conveyance or operating mechanism from the premises is forbidden until permission to do so has been granted by the commissioner.

**Type of Conveyance**

Escalator  Elevator  Special Purpose  Other  \_\_\_\_\_

**Describe fully how accident occurred and state what injured was doing when the accident occurred:**

Are there any videotapes or photographs of the incident?  Yes  No (if yes, please mail copies)

Were safety orders issued at the last inspection?  Yes  No

Are repairs needed now?  Yes  No (Detail Repairs Needed)

Does the conveyance have a Permit to Operate?  Yes  No

Date of Last Inspection:

Has conveyance been secured from operation?  Yes  No If no, why?

Conveyance Contractor Notified:  Yes  No  
 If Yes, Company Contact(s) and Telephone Number(s)

WITNESS(ES)			
Name	Address	Phone #	Approx. Age

**Number of people injured:** *\*\*Please complete a set of questions for each injured person\*\**

**Name of 1<sup>st</sup> injured:** Age: Date of injury: Time of injury:

Address:

City: State: Telephone:

Were injuries to this person fatal  Yes  No Did injury to this person require hospitalization?  Yes  No

Did injury to this person require first aid?  Yes  No

Nature of injury:

**Name of 2<sup>nd</sup> injured:** Age: Date of injury: Time of injury:

Address:

City: State: Telephone:

Were injuries to this person fatal  Yes  No Did injury to this person require hospitalization?  Yes  No

Did injury to this person require first aid?  Yes  No

Nature of injury:

**Name of 3<sup>rd</sup> injured:** Age: Date of injury: Time of injury:

Address:

City: State: Telephone:

Were injuries to this person fatal  Yes  No Did injury to this person require hospitalization?  Yes  No

Did injury to this person require first aid?  Yes  No

Nature of injury:

***I hereby certify pursuant to the laws of the State of Iowa that the above information is true and correct to the best of my knowledge and belief.***

Name of Person Filing Report (Please Print Clearly)	Company or Firm
Signature of Person Filing Report	Date of this Report

For Office Use Only

Acquired Written Report from First Responder (if applicable)  Acquired Hospital Report (if applicable)   
Report Filed Immediately w/ Division of Labor Services

Elevators/Forms/Conveyance Accident Report.doc 1-22-07 R 12-4-07vep Revised 1-22-09 Revised 1-12-11 vep