



**Department of Commerce**

Division of Industrial Compliance  
John R. Kasich, Governor  
Jacqueline T. Williams, Director

**ACCIDENT REPORT**

**This form shall be filed with the Division of Industrial Compliance within 72 hours of any accident that results in a fatality or bodily injury requiring medical attention involving the operation or usage of an elevator device subject to sections 4105.0 to 4105.21 of the Ohio Revised Code.**

**Location**

State ID: \_\_\_\_\_

Name of Building: \_\_\_\_\_ County: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Accident Information**

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Name of Injured: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: **OH** Zip: \_\_\_\_\_

Name of Injured: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: **OH** Zip: \_\_\_\_\_

Name of Injured: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: **OH** Zip: \_\_\_\_\_

**Description of the Accident:**

(Explain what occurred, the direction the unit was traveling, list any witness and describe the nature of the injuries.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DIC 4613

Revised 08-16-13