



# REPORT OF INCIDENT

State Form 40141 (R5 / 8-19)

INDIANA DEPARTMENT OF  
NATURAL RESOURCES

**INSTRUCTIONS:** Within ten (10) days, distribute the completed form to:

\*the Director of Safety. (The Director of Safety will forward a copy to the Attorney General, upon request.)

\*the DNR division representative involved in the incident.

\*the original form will be retained by the originator.

TO: <b>ATTORNEY GENERAL'S OFFICE, INVESTIGATION DIVISION</b>
FROM: (PROPERTY)
AGENCY / DIVISION

<b>NOTICE</b>
This report is prepared by and for State use. It shall not be published or disseminated to anyone without specific authorization from a representative of the office of the Attorney General of Indiana or a representative of the state agency with the authority to release said information.

<b>TIME, PLACE, AND ENVIRONMENT</b>			
<input type="checkbox"/> State Employee <input type="checkbox"/> Not a State Employee	Date of Incident (month, day, year)	Day of Week	Tort Claim Procedure Issued? <input type="checkbox"/> Yes <input type="checkbox"/> No
Local Time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Exact Location of Incident		
WEATHER CONDITIONS: <input type="checkbox"/> Clear <input type="checkbox"/> Freezing Rain <input type="checkbox"/> Cloudy <input type="checkbox"/> Fog / Smoke <input type="checkbox"/> Rain <input type="checkbox"/> Other (Describe) <input type="checkbox"/> Snow <input type="checkbox"/> Sleet / Hail	LIGHT CONDITIONS: <input type="checkbox"/> Daylight <input type="checkbox"/> Dawn / Dusk <input type="checkbox"/> Dark (Street Lights On) <input type="checkbox"/> Dark (Street Lights Off) <input type="checkbox"/> Dark (No Street Lights)	TYPE OF INCIDENT (check all that apply): <input type="checkbox"/> Personal Incident <input type="checkbox"/> Property Damage <input type="checkbox"/> Fatality <input type="checkbox"/> Vehicle Incident	
Photo Included? <input type="checkbox"/> Yes <input type="checkbox"/> No		Property Map Included? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>INJURED PERSON</b>	
Name of Injured Person	Telephone Number (      )
Address (number and street)	Date of Birth (month, day, year)
City, State, and ZIP Code	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>BODILY INJURY STATUS</b>						
Below is a list indicating <b>Area of Injury</b> . By using the letter codes listed under <b>Type of Injury</b> (shaded area below), list the appropriate letter(s) next to the affected <b>Area of Injury</b> . (Example: A laceration and contusion to the head would be indicated by: Head..... <u>A, B</u> )						
<b>Area of Injury</b>						
Head..... _____	Shoulder..... _____	Wrist..... _____	Ankle..... _____	Chest..... _____	Back..... _____	Knee..... _____
Face..... _____	Collarbone.. _____	Abdomen... _____	Foot..... _____	Hip..... _____	Thumb..... _____	Lower leg.. _____
Eye..... _____	Elbow..... _____	Thigh..... _____	Skin..... _____	Upper Arm. _____	Hand..... _____	Instep..... _____
Tooth... .. _____	Ribs..... _____	Groin..... _____	Neck..... _____	Forearm.... _____	Finger..... _____	Toe..... _____
<b>Type of Injury</b>						
Laceration..... A	Bite ..... F	Dermatitis ..... K	Shortness of breath..... P			
Contusion... .. B	Burn ..... G	Rash..... L	Allergic reaction... .. Q			
Infection... .. C	Nausea..... H	Fracture..... M	Pains ..... R			
Foreign body ..... D	Dizziness ..... I	Strain..... N	Miscellaneous..... S			
Puncture... .. E	Irritation..... J	Sprain..... O	Unknown ..... T			

VICTIM STATUS <input type="checkbox"/> Conscious <input type="checkbox"/> Semi-conscious <input type="checkbox"/> Unconscious <input type="checkbox"/> Dead	Received First Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Medical Treatment If Yes, by whom? _____	<input type="checkbox"/> Ambulance (Name of Ambulance Service) _____
DISPOSITION <input type="checkbox"/> Went Home <input type="checkbox"/> Went to Hospital <input type="checkbox"/> Saw Physician	_____	_____

<b>WITNESS</b>	
Name	Telephone Number (      )
Address (number and street)	City, State, and ZIP Code

(Continued on back)

### LAW ENFORCEMENT

Name of Investigating Officer	Badge / Identification Number
Department	Law Enforcement Called? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, by whom?

### OTHER REPORTS

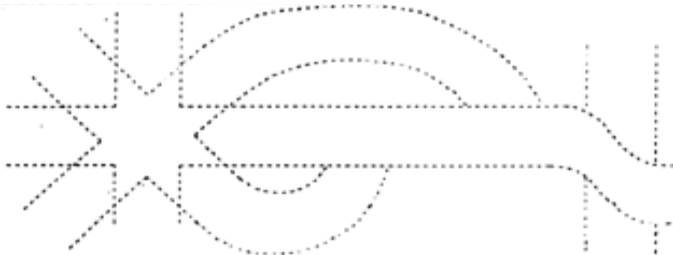


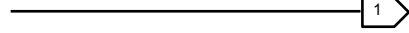

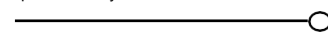
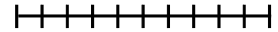
Indiana Operator's Accident Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	Investigative Officer's Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	Notification of ejection issued <input type="checkbox"/> Yes <input type="checkbox"/> No
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#### VEHICLE 1

#### VEHICLE 2

Print Driver's Name (Last, First, MI)				Print Driver's Name (Last, First, MI)			
Address (Street, City, State, and ZIP Code)				Address (Street, City, State, and ZIP Code)			
Sex	Date of Birth (month, day, year)	License Type		Sex	Date of Birth (month, day, year)	License Type	
License State	Driver's License Number	Restrictions		License State	Driver's License Number	Restrictions	
Color	Vehicle Year	Make	Model Name	Color	Vehicle Year	Make	Model Name
Vehicle Type	License Year	LicensePlate/Commission Number	License State	Vehicle Type	License Year	LicensePlate/Commission Number	License State
Fire? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Axles	Towed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Fire? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Axles	Towed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Posted Speed Limit	Direction of Travel	Number of Occupants		Posted Speed Limit	Direction of Travel	Number of Occupants	
Registered Owner's Name				Registered Owner's Name			
Address (Street, City, State, and ZIP Code)				Address (Street, City, State, and ZIP Code)			

### DIAGRAM (Refer to Vehicles by Number.)

<b>INDICATE ON DIAGRAM WHAT HAPPENED</b> 	Indicate North By Arrow. 	<b>INSTRUCTIONS</b> 1. Follow dotted lines to draw outline of roadway at place of accident. 2. Number each vehicle and show direction of travel by arrow.  3. Use solid line to show path before accident;  dotted line after accident:  4. Show pedestrian by:  5. Show railroad by:  6. Show distance and direction to landmarks; identify landmarks by name or number. 7. Show traffic controls.
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Fully describe the incident: (Include facts - who, what, where, when from beginning to resolution. Use a separate sheet of paper, if necessary.)


### SIGNATURES

***Authorized personnel shall complete and process this report without undue delay.***

Report Prepared By:	Title	Date (month, day, year)
Was Incident Job Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature of Immediate Supervisor	Date (month, day, year)