

**Iowa Division of Labor
Elevator Safety**

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FOR OFFICE USE ONLY	
Received date: _____	Time: _____
Notified date: _____	Time: _____
Filed on time: Yes No	
First responder written report: Yes No	
Hospital report: Yes No	
Initials: _____	

Conveyance Accident Report

The owner or duly authorized agent shall immediately notify the Labor 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 \$2,000.00. Notification shall be in writing, shall specifically identify the conveyance, state identification number, owner and description of accident. When a personal injury 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 has been re-inspected. Any repairs or alterations shall be approved by the Labor 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 Labor Commissioner.

Owner's name	Owner's ID	State ID	Manufacturer	Accident date/time	
Accident building address			City	State	Zip
Owner's address			City	State	Zip
Phone number	Fax number		Email address		
Type of conveyance:	Escalator	Elevator	Special purpose	Other:	
Describe in detail what happened:					

Number of people injured:	Are there videotapes or photographs of the incident?		Yes	No (If yes, send copies)
Were safety orders issued at the last inspection?	Yes	No	Are repairs needed now?	Yes No
Does the conveyance have a permit to operate?	Yes	No	(If yes, attach details of repairs needed)	
Has conveyance been secured from operation?	Yes	No	Date of last inspection:	
Has conveyance contractor been notified?	Yes	No	If no, why?	
	Yes	No	If yes, name/phone number:	

Conveyance Accident Report

Witnesses

Name	Address	Phone number	Age
Name	Address	Phone number	Age
Name	Address	Phone number	Age
Name	Address	Phone number	Age

People Injured

1. Name		Age	Phone number	
Address		City		State Zip
Email address	If minor, parent/guardian name		Phone number	
Injuries: Fatal?	Yes	No	Require hospitalization?	Yes No
Require first aid? Yes No				
Nature of injury:				
2. Name		Age	Phone number	
Address		City		State Zip
Email address	If minor, parent/guardian name		Phone number	
Injuries: Fatal?	Yes	No	Require hospitalization?	Yes No
Require first aid? Yes No				
Nature of injury:				
3. Name		Age	Phone number	
Address		City		State Zip
Email address	If minor, parent/guardian name		Phone number	
Injuries: Fatal?	Yes	No	Require hospitalization?	Yes No
Require first aid? Yes No				
Nature of injury:				

I certify that the information on this form and attachments (if any) is true and accurate to the best of my knowledge.

Name of Person Filing Report	Phone number	Company or Firm Name	Signature	Date
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