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| --- | --- |
|  | **Commonwealth of Massachusetts**  **Division of Occupational Licensure**  **Office of Public Safety and Inspections**  **ELEVATOR INCIDENT REPORT**  **E-mail to:** [**elevator.supervisor@mass.gov**](mailto:elevator.supervisor@mass.gov) |

***All elevator accidents or unsafe conditions must be reported to Massachusetts Emergency Management (MEMA) at (508) 820-1444 within one hour of occurrence. This form must be completed in full and submitted to the Office of Public Safety and Inspections (OPSI) within 48 hours of reporting the incident to MEMA.***

***Email the completed form to:*** [***elevator.supervisor@mass.gov***](mailto:elevator.supervisor@mass.gov)

***This form is located at:*** [***https://www.mass.gov/lists/elevator-forms-applications***](https://www.mass.gov/lists/elevator-forms-applications)

***emergency medical attention or hospitalization.” (524 CMR 4.02)***

## ***PLEASE PROVIDE COMPLETE INFORMATION BELOW***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Elevator Owner:** |  | | **Elevator State ID#** |  |
| **Elevator Location Address:** |  | | **Incident Location:** |  |
|  |  | | **Certificate Expiration Date:** |  |
| **Elevator Owner Contact Name:** |  | | **Date of Incident:** |  |
| **Elevator Owner Phone #:**  **Elevator Owner E-mail:** |  | | **Time of Incident:** |  |
|  |  | |  |  |
| **Elevator Company Name:** |  | | | |
| **Date of First Report to Office of Public Safety:** |  | | **Time of First Report to Office:** |  |
| **Name of Person Filing Report (if different than Owner Contact):** |  | | **Phone # (if different than Owner Contact** |  |
| **How was owner notified of the incident?** |  | | | |
| **Was the elevator taken out of service at the time of the incident?**  **Yes**  **No** | | **Has the elevator been put back into service?**  **Yes**  **No** | **If yes, on what date was the elevator put back in service and who authorized its reactivation?** | |

## ***WITNESS INFORMATION***

|  |  |  |  |
| --- | --- | --- | --- |
| ***WITNESSES*** | **Name of Witnesses or Persons Present** | **Address** | **Phone** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## ***INCIDENT/VICTIM INFORMATION***

|  |  |  |  |
| --- | --- | --- | --- |
| **INJURED 1** | **Name of injured:** | **Telephone Number:** | **Sex**:  **Female**  **Male** |
| **DOB:** | **Street Address:** **City/State/Zip Code** | |
| **Was there an on-scene medical provider?**  **Yes**  **No** | **If yes, on-scene medical provider's name and telephone #:** | |
| **Hospitalized?**  **Yes**  **No**  **Nature of injury:** | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **INJURED 2** | **Name of injured:** | **Telephone Number:** | **Sex:**  **Female**  **Male** |
| **DOB:** | **Street Address:** **City/State/Zip Code** | |
| **Was there an on-scene medical provider?**  Yes  No | **If yes, on-scene medical provider's name and telephone #:** | |
| **Hospitalized?**  **Yes**  **No**  **Nature of injury:** | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **INJURED 3** | **Name of injured:** | **Telephone Number:** | **Sex:**  **Female**  **Male** |
| **DOB:** | **Street Address:** **City/State/Zip Code:** | |
| **Was there an on-scene medical provider?**  **Yes**  **No** | **If yes, on-scene medical provider's name and telephone #:** | |
| **Hospitalized?**  **Yes**   **No**  **Nature of injury:** | | |

## ***INCIDENT SUMMARY***

**Name of person filing report:**       **Date:**

***By typing your name above you agree that this is valid as your signature.***