STATE OF WISCONSIN
Department of Safety and Professional Services
1400 E Washington Ave.
Madison WI 53703

SAFETY AND BUILDINGS DIVISION
Integrated Services Bureau
Elevator Safety Program
P.O. Box 2658
Madison, WI 53701-2658

Governor Scott Walker **Secretary Dave Ross**

Personal information you provide may be used for secondary purposes [Privacy Law s.15.04 (1)(m)].

ELEVATOR / ESCALATOR ACCIDENT REPORT

Building Name	**Owners Name**	**Registration Tag No.**
Street Address	**Address**	**Regulated Object ID.**
City, State, Zip	**City, State, Zip**	**Manufacturer**

1. **Comm 18.1008(1) (a) Accidents to be reported.** Whenever an elevator or other installation covered by this chapter causes injury to any person, the owner or person in control of the elevator shall notify the department within 48 hours of the accident. The report shall include the date and time of the accident, the location of the elevator or device involved in the accident and description of the accident.

   Note: The department may be contacted at phone: (608) 266-7548 during normal business hours. The State Division of Emergency Management can be contacted at (800) 943-0003 during non-business hours.

Name of Injured: Date of Injury: Time of Injury:

Address: City: State: Telephone:

Nature of Injury: Did Accident Cause a Fatality: ☐ Yes ☐ No

2. **Comm 18.1008(4) (b) Operation discontinued.** When an accident involves the failure or destruction of an elevator or other installation covered by this chapter and results in injury to a person who requires immediate medical attention, the elevator or device shall be taken out of service and shall not be used again until authorized by the department.
3. **Comm 18.1008(4) (c) Removal of parts restricted**. No part of the damaged installation, construction or operating mechanism shall be removed from the premises until the department grants permission.

Was Elevator Operated after Accident: ☐ Yes ☐ No

If Yes Reason:

Was the Elevator Contractor or Inspector Notified: ☐Yes ☐No

If Yes Name(s) and Telephone Number(s)

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

Name(s) and Telephone Number(s) of Wittiness:

Does Elevator have a Permit to Operate: ☐ Yes ☐ No	Date of Last Inspection:
Name of Person Filing Report (Please Print Clearly)	Company or Firm
Signature of Person Filing Report	Date of this Report

Reports Shall Be Filed With the Department of Safety & Professional Services Within 48 Hours of Accident

A Copy of This Report Shall Be Forwarded to the Owner