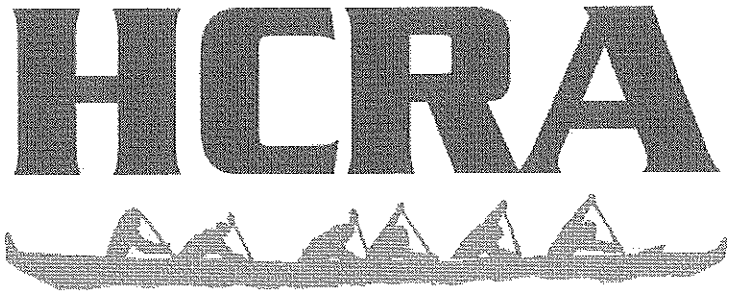

Within 7 days of an incident, send completed Insurance Incident Reporting forms to:

Renee Birgado/Barbara Aguilar
Servco Insurance Services
reneeab@servco.com
barbaraa@servco.com
808-564-2595 (fax)

Copy: Keri Mehling (kerionmaui@yahoo.com)
Jerry Halverson (j.jfh@hawaiiantel.net)

Be sure to include information for the contact person at the Canoe Club that is submitting the report!

Include the waiver for the person(s) injured.

Include the crew list with phone numbers for the crew members & each witness statement.

If an escort boat is involved, include the escort boat waiver and contact information.

PERSONAL INJURY ACCIDENT REPORT

(To be completed by injured party in complete detail)

YOUR NAME:_____

LOCAL / HOTEL ADDRESS:_____PHONE:_____

HOME ADDRESS:_____PHONE:_____

OCCUPATION / POSITION:_____BUS. PHONE:_____

YOUR DATE OF BIRTH:_____SOCIAL SECURITY NO.:_____

DATE / TIME OF ACCIDENT:_____

WHERE DID THE ACCIDENT HAPPEN (Please be specific)_____

_____

PLEASE GIVE A DETAILED DESCRIPTION OF THE ACCIDENT (Use back of page if necessary)

_____

_____

_____

_____

DID ANYONE ELSE WITNESS THE ACCIDENT? YES ☐ NO ☐ IF SO, WHO?

NAME / ADDRESS:_____PHONE:_____

NAME / ADDRESS:_____PHONE:_____

NAME / ADDRESS:_____PHONE:_____

WHAT WERE YOU DOING WHEN THE ACCIDENT HAPPENED?_____

_____

_____

WAS ANY FOOD OR DRINK INGESTED? _____

YES ☐ NO ☐ IF SO, WHAT TYPE OF FOOD OR DRINK WAS INVOLVED?_____

_____

WAS FIRST AID ADMINISTERED? YES ☐ NO ☐ IF SO, WHO PROVIDED IT AND WHAT WAS PROVIDED?

_____

_____

NAME AND ADDRESS OF YOUR FAMILY DOCTOR_____

_____

NAME AND ADDRESS OF DOCTOR WHO TREATED YOU FOR THIS INJURY / ILLNESS _____

_____

_____

SIGNATURE:_____ DATE:_____

(Use back of page if necessary)

PERSONAL INJURY WITNESS REPORT

(To be completed by Witness to Injury)

NAME OF WITNESS: _____ (Check one) Passenger ☐ Crew ☐

NAME OF PERSON INJURED: _____ VESSEL: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

EXACT LOCATION WHERE ACCIDENT OCCURRED: _____

_____

PLEASE GIVE A DETAILED DESCRIPTION OF THE ACCIDENT (use back of page if necessary)

_____

_____

_____

WEATHER & SEA CONDITIONS: _____

WHAT WERE YOU DOING AT THE TIME OF THE ACCIDENT? _____

_____

_____

HOW FAR WERE YOU FROM THE INJURED PERSON? _____

GIVE IDENTITY OF ANY OTHER WITNESSES:

NAME / ADDRESS: _____ PHONE: _____

NAME / ADDRESS: _____ PHONE: _____

WAS FIRST AID ADMINISTERED? YES___ NO____ IF SO, WHO PROVIDED IT? _____

_____

PLEASE DESCRIBE THE TYPE OF INJURY SUSTAINED? _____

WAS THE INJURED PERSON TAKEN TO A PHYSICIAN OR HOSPITAL? YES____ NO_____

NAME / ADDRESS OF PHYSICIAN OR HOSPITAL: _____

ADDITIONAL INFORMATION REGARDING THE ACCIDENT? _____

_____

_____

SIGNATURE OF WITNESS: _____ DATE: _____

HOME ADDRESS: _____ HOME PH: _____

LOCAL HOTEL / ADDRESS: _____ LOCAL PH: _____

EMPLOYMENT POSITION: _____ NO. OF YEARS: _____

WORK ADDRESS: _____ WORK PH: _____

(Use back page if necessary)