Iowa Division of Labor
Elevator Safety
150 Des Moines Street
Des Moines, IA 50309-1836
Phone: 515-725-5612/515-725-5608
Fax: 515-242-5076
elevators@iwd.iowa.gov
www.iowaelevators.gov

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 shall promptly notify the Labor Commissioner if a personal injury accident requires the service of a physician; if a personal injury accident causes disability exceeding one day; or, if a conveyance suffers damage that will require more than one hour of mechanic's time (excluding travel) to repair. Notification shall be in writing and shall include the state identification number, owner, and description of the accident. If a report is required and any part of the conveyance or its operating mechanism has failed or been destroyed, the use of the conveyance is forbidden until it has been inspected and approved by the Labor Commissioner. The removal of any part of the damaged conveyance or operating mechanism from the premises is forbidden until permission 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** (If yes, attach details of repairs needed)
Does the conveyance have a permit to operate? ☐ **Yes** ☐ **No**	Date of last inspection:
Has conveyance been secured from operation? ☐ **Yes** ☐ **No** If no, why?	
Has conveyance contractor been notified? ☐ **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**

Please complete a set of questions for each injured person, if number of injured is more than 3 an additional injured report can be found at www.iowaelevators.gov under Quick Links.