Customer Incident Form

Date/Time: ____________________ Shift Manager's Name: _________________________Store Number: __________

Customer Information:

Customer Name: ____ Gender: M___F___Pregnant?:__________

Address: ______________________________________ City: _________________ State:__________Zip: __________

Date of Birth: __________________ Parent/Guardian: (if under 18) ____

Home Phone: _________________________________ Work or Cell Phone: _________________________________

Date of Incident: ______________________________ Location of Incident: _________________________________

Time of Incident: ______________________________ Date/Time Incident Reported:___________________________

Incident Reported To:___________________________ In Person or Over the Phone?:__________________________

Witness Name/Phone:____

How did the customer leave the store? ____

Description: ____

____

____

____

____

Alleged Foreign Object/Injury from Foreign Object:

Product: ______________________________________ Describe Object: ____________________________________

Case WSI#: ____________________________________ WRIN#: ____

Use-Through Date: _____________________________ Product Code or Other: _________________________________

Where is the Object/Product Now: ____

Was the Medical Treatment Administered: ________Yes ____________No ____________Unknown ____________

If yes: Were Paramedics Called: ________Yes ____________No ____________Unknown ____________

Was the Customer Hospitalized: ___Yes ____________No ____________Unknown ____________

Did Customer See a Doctor:______Yes ____________No ____________Unknown ____________

Describe Injury (if any) in detail: ____

____

____

Alleged Illness or Consumption Incident:

What time was food eaten: _______________________ Which products were eaten: __________________________

Where was food eaten: __________Restaurant __________________Home __________Other __________________

Where is the product now: ____

What Date and Time Did the Symptoms Begin: ____

Describe the Symptoms: ____

Was the Medical Treatment Administered: ________Yes ____________No ____________Unknown ____________

If yes: Were Paramedics Called: ________Yes ____________No ____________Unknown ____________

Was the Customer Hospitalized: ___Yes ____________No ____________Unknown ____________

Did Customer See a Doctor:______Yes ____________No ____________Unknown ____________

This information needs to be sent to Essig Management as soon as the incident occurs. All information must be completed to file a report. This is a State of Missouri Requirement. No report can be filed unless complete.
Essig Management Fax: (816) 903-5101.

Customer Incident Form

Continued: Date/Time: ________________ Customer Name: ________________________________

Alleged PlayPlace Incident:

Did the Incident Happen in the PlayPlace (Indoor): ________________________________

Was the Customer Injured: ______________________ Body Part Injured: ____________________

Was the Medical Treatment Administered: Yes No Unknown

If yes: Were Paramedics Called: Yes No Unknown

Was the Customer Hospitalized: Yes No Unknown

Did Customer See a Doctor: Yes No Unknown

Did the Injury Involve a Piece of Equipment: Yes No Unknown

If Yes, Describe in Detail the Piece of Equipment: ________________________________

____

Describe the Incident/Injury in Detail: ____

____

Alleged Premium/Promotional Product Incident:

Type of Promotional Product: Under 3 Happy Meal Toy Happy Meal Toy SLP (Self-Liquidating Product)

Birthday Party Item Non-Food Giveaway Other:

What Was the Name of the Promotion: ____

What Was the Name of the Promotional Product: ________________________________

Describe the Promotional Product (Including Letter/Number Factory Code, Located on Bottom of Toy) ____________

____

Was the Customer Injured: Yes No Unknown Body Part Injured: ____________

If yes: Were Paramedics Called: Yes No Unknown

Was the Customer Hospitalized: Yes No Unknown

Did Customer See a Doctor: Yes No Unknown

Describe Incident/Injury in Detail: ____

____

Alleged Customer Accident/Property Damage:

Type of Incident (circle one): Customer Accident Property Damage Other:

Describe Customer Accident/Property Damage: ________________________________

____

Was the Medical Treatment Administered: Yes No Unknown

If yes: Were Paramedics Called: Yes No Unknown

Was the Customer Hospitalized: Yes No Unknown

Did Customer See a Doctor: Yes No Unknown

Additional Information that could be helpful in filing this claim: ____________________

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