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| F-fd-23.docx (New 7/16) | | | | | |
| C:\Users\mackesl\Desktop\FORMS\DATCPlogo_1in_g.jpg | Wisconsin Department of Agriculture, Trade and Consumer Protection  *Division of Food and Recreational Safety,* PO Box 8911, Madison, WI 53708-8911  Phone: (608) 224-4720 Fax: (608) 224-4710 | | | | |
| SWIMMING POOL AND WATER ATTRACTION DEATH, INJURY AND ILLNESS REPORT | | | | | |
|  | | | Wis. Admin. Code ch. ATCP 76 | | |
| ATCP 76.32 (2) The operator shall report incidents resulting in death, or serious injury or illness that requires assistance from emergency medical personnel, by the end of the next working day following the incident by telephone or fax to the department or agent. | | | | | |
| **Please use one form for each injured party.** The operator shall maintain a copy of this report for at least seven years. | | | | | |
| **Report only those injuries or illnesses that require assistance from emergency medical personnel.** | | | | | |
| **Please print all information. Mail or fax report to the address listed at the top of the form.** | | | | | |
| ESTABLISHMENT NAME | | | | LICENSE / ID NO. | |
| ESTABLISHMENT ADDRESS STREET | | CITY | | STATE | ZIP |
| LEGAL LICENSEE NAME (Name of sole proprietor, partnership, LLC, LLP, or Inc.) | | CONTACT PERSON | | PHONE:  (   )     - | |
| NAME / TYPE OF POOL OR WATER ATTRACTION | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| INJURED PARTY INFORMATION | | | | | | |
| NAME OF INJURED PARTY | | DATE OF BIRTH | | AGE | | GENDER |
| INJURED PARTY ADDRESS | CITY | | | | STATE | ZIP |
| INJURED PARTY WAS:  EMPLOYEE  PATRON  OTHER | | | | PHONE:  (   )     - | | |
| CONTACT PERSON FOR INJURED PARTY | | | | CONTACT PHONE:  (   )     - | | |
| TYPE OF INCIDENT:  DEATH  INJURY  ILLNESS | | DATE AND TIME OF INCIDENT | | | | |
| INCIDENT INFORMATION | | | | | | |
| DETAILED DESCRIPTION OF INCIDENT (use back side of form for additional pages, if needed) | | | | | | |
| LIST NAME(S) OF LIFEGUARD(S) ON DUTY | | | | | | |
|  |  | | | | | |
|  |  | | | | | |
| SIGNATURE REQUIRED | | | | | | |
| NAME OF PERSON COMPLETING FORM (please print) | | | POSITION / TITLE | | | |
| SIGNATURE – PERSON COMPLETING FORM | | | DATE SIGNED | | | |

*Personal information you provide may be used for purposes other than that for which it was originally collected. Wis. Stat. § 15.04(1)(m)*

This institution is an equal opportunity employer.