

STATE OF NEW HAMPSHIRE  
DEPARTMENT OF SAFETY  
DIVISION OF SAFETY SERVICES  
TRAMWAY AND AMUSEMENT RIDE SAFETY BUREAU  
31 DOCK RD  
GILFORD NH 03249

**AMUSEMENT RIDE ACCIDENT REPORT**

Pursuant to NH SAF-C 1405.04 (I), an Amusement Ride Accident report shall be completed for all accidents involving **PERSONAL INJURY OR MECHANICAL FAILURE** on an amusement ride or device. This accident report shall be sent by the Operator to the Division of Safety Services at the above address **within five (5) days** of the accident.

**ACCIDENT REPORT MUST BE COMPLETELY FILLED OUT, SIGNED AND DATED**

**Date of Report:** \_\_\_\_\_

**Name of Amusement Ride Company/Park** \_\_\_\_\_

Permanent Mailing Address: \_\_\_\_\_

Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**NH Ride Registration No.** \_\_\_\_\_

**Name of Ride on which accident occurred:** \_\_\_\_\_

**Type of Ride on which accident occurred:** \_\_\_\_\_

**Date of Accident** \_\_\_\_\_ **Time of Day** \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

**Exact Location of accident:** (Fix location precisely) \_\_\_\_\_

**Persons killed or injured:**

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Describe Injury \_\_\_\_\_

**Persons killed or injured:**

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Describe Injury \_\_\_\_\_

**Weather conditions at time of accident:** \_\_\_\_\_

**Name and address of physical operator in charge**

Name \_\_\_\_\_

Address \_\_\_\_\_

**Attendant(s) at time of accident:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

**Briefly describe how the accident occurred:** \_\_\_\_\_  
\_\_\_\_\_

**Operator's OPINION as to cause of accident:** \_\_\_\_\_  
\_\_\_\_\_

**Known witness(es):**

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

**Is the ride registered in New Hampshire?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Has this ride been inspected pursuant to SAF-C 1404.02** Yes \_\_\_\_\_ No \_\_\_\_\_

Date of last inspection \_\_\_\_\_

Name of Inspector \_\_\_\_\_

Address \_\_\_\_\_

**Were safety devices as required by SAF-C 1400 installed?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Name of hospital/doctor where injured person was taken:** \_\_\_\_\_

**Was first aid equipment available at the scene of the accident?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Detailed description of mechanical failure:** \_\_\_\_\_  
\_\_\_\_\_

Signature of Operator \_\_\_\_\_

Please print name: \_\_\_\_\_

**PLEASE RETURN THIS FORM WITHIN 5 DAYS TO: NH DEPT. OF SAFETY  
TRAMWAY & A.R. SAFETY  
31 DOCK RD  
GILFORD NH 03249-7627**

**N.H. DEPARTMENT OF SAFETY  
DIVISION OF SAFETY SERVICES  
TRAMWAY AND AMUSEMENT RIDE SAFETY BUREAU  
31 DOCK RD  
GILFORD NH 03249**

**AMUSEMENT RIDE ACCIDENT REPORT**

Pursuant to **NH SAF-C 1405.04** any amusement ride accident causing death, serious injury or damage to the ride or device or any of its components shall immediately be reported to the Department of Safety, Tramway and Amusement Ride Safety Bureau.

During normal business hours call 603 293-0094. At all other times, call State Police Dispatch at 603 271-3636.

**DATE AND TIME OF INITIAL TELEPHONE REPORT:** \_\_\_\_\_

In addition to immediate reporting by phone, the Amusement Ride Accident report form shall be completed for all accidents involving PERSONAL INJURY OR MECHANICAL FAILURE on an amusement ride or device. This accident report shall be sent by the Operator to the Division of Safety Services at the above address **within five (5)** days of the accident.

**ACCIDENT REPORT MUST BE COMLETELY FILLED OUT, SIGNED AND DATED**

Date of Report: \_\_\_\_\_ NH Ride Registration No. NH-\_\_\_\_\_

Name of Amusement Ride Company/Park \_\_\_\_\_  
Permanent Mailing Address: \_\_\_\_\_  
Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Ride on which accident occurred: \_\_\_\_\_  
Type of Ride on which accident occurred: \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Day \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

Exact Location of accident: (Fix location precisely) \_\_\_\_\_  
\_\_\_\_\_

Persons killed or injured:  
Name \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
Describe Injury \_\_\_\_\_

Persons killed or injured:  
Name \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
Describe Injury \_\_\_\_\_

Weather conditions at time of accident: \_\_\_\_\_

Name and address of physical operator in charge:  
Name \_\_\_\_\_  
Address \_\_\_\_\_

**Attendant(s) at time of accident:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

**Briefly describe how the accident occurred:** \_\_\_\_\_

**Operator's OPINION as to cause of accident:** \_\_\_\_\_

**Known witness(es):**

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

**Is the ride currently registered in New Hampshire?** Yes\_\_\_\_ No\_\_\_\_

**Has this ride been inspected pursuant to SAF-C 1402.02?** Yes\_\_\_\_ No\_\_\_\_

Date of last inspection \_\_\_\_\_

Name of Inspector \_\_\_\_\_

Address \_\_\_\_\_

**Were safety devices as required by SAF-C 1400 installed?** Yes\_\_\_\_ No\_\_\_\_

**Name of hospital/doctor where injured person was taken:** \_\_\_\_\_

**Was first aid equipment available at the scene of the accident?** Yes\_\_\_\_ No\_\_\_\_

**Detailed description of mechanical failure:** \_\_\_\_\_

**Signature of Operator** \_\_\_\_\_

Please print or type name: \_\_\_\_\_

**PLEASE RETURN THIS FORM WITHIN 5 DAYS TO: NH DEPT. OF SAFETY  
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