



**TEXAS DEPARTMENT OF INSURANCE**  
Loss Control Regulation-Mail Code 103-9A  
333 Guadalupe, P. O. Box 149104  
Austin, Texas 78714-9104  
(512) 322-3435 Fax (512) 305-7425

**QUARTERLY INJURY REPORT**  
**AMUSEMENT RIDE SAFETY INSPECTION AND INSURANCE ACT**

In accordance with Chapter 2151, Amusement Ride Safety Inspection and Insurance Act of the Texas Occupations Code and 28 TAC §§5.9001 -- 5.9014, the following report of injury related to an amusement ride in any state resulting in death or requiring medical treatment as defined in the Act, is hereby made for the calendar year quarter.

FROM: \_\_\_\_\_ TO: \_\_\_\_\_

OWNER/OPERATOR (INSURED) \_\_\_\_\_

ADDRESS \_\_\_\_\_

SIGNATURE OF OWNER/OPERATOR \_\_\_\_\_

\_\_\_\_\_ Number of injuries requiring medical treatment or deaths relating to an amusement ride (complete section below for each reported death or injury).

**THE QUARTERLY INJURY REPORT MUST BE FILED WITH THE DEPARTMENT AND MAINTAINED FOR TWO YEARS AT THE LOCATION WHERE THE RIDE IS OPERATED AND BE AVAILABLE FOR INSPECTION BY A MUNICIPAL, COUNTY OR STATE LAW ENFORCEMENT OFFICIAL.**

**IF NO INJURIES WERE SUSTAINED, A REPORT IS NOT REQUIRED.**

Date of Injury: \_\_\_\_\_

Amusement Ride Name: \_\_\_\_\_ Serial No.: \_\_\_\_\_  
(if applicable to identification of ride)

Sex/Age of Injured Person: \_\_\_\_\_ Name of Injured: \_\_\_\_\_  
(optional)

Body Part Injured: \_\_\_\_\_

Description/Type of Injury: \_\_\_\_\_

Cause of Injury: \_\_\_\_\_

Other Circumstances – if appropriate: \_\_\_\_\_

**[(SEE REVERSE SIDE FOR ADDITIONAL ENTRIES)]**

QUARTERLY INJURY REPORT (CONTINUED)

**OWNER OPERATOR (INSURED)**

Date of Injury: \_\_\_\_\_

Amusement Ride Name: \_\_\_\_\_ Serial No.: \_\_\_\_\_  
(if applicable to identification of ride)

Sex/Age of Injured Person: \_\_\_\_\_ Name of Injured: \_\_\_\_\_  
(optional)

Body Part Injured: \_\_\_\_\_

Description/Type of Injury: \_\_\_\_\_

Cause of Injury: \_\_\_\_\_

Other Circumstances - if appropriate: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Amusement Ride Name: \_\_\_\_\_ Serial No.: \_\_\_\_\_  
(if applicable to identification of ride)

Sex/Age of Injured Person: \_\_\_\_\_ Name of Injured: \_\_\_\_\_  
(optional)

Body Part Injured: \_\_\_\_\_

Description/Type of Injury: \_\_\_\_\_

Cause of Injury: \_\_\_\_\_

Other Circumstances - if appropriate: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Amusement Ride Name: \_\_\_\_\_ Serial No.: \_\_\_\_\_  
(if applicable to identification of ride)

Sex/Age of Injured Person: \_\_\_\_\_ Name of Injured: \_\_\_\_\_  
(optional)

Body Part Injured: \_\_\_\_\_

Description/Type of Injury: \_\_\_\_\_

Cause of Injury: \_\_\_\_\_

Other Circumstances - if appropriate: \_\_\_\_\_

**REPRODUCE THIS SHEET AS MANY TIMES AS NEEDED**