

GENERAL LIABILITY INCIDENT REPORT

INSURED LOCATION

Name & Address of Office/Location of Incident:		Date:
Name and Title of Employee Completing This Report: <i>(Required)</i>		Telephone:
Name & Title of Employee With Best Knowledge of Incident:		
Location of Incident:	Accident/Loss Date:	Time:

INJURED PARTY *(If Applicable)*

Name: (Last, First, Middle Initial)		
Address: (Street, City, State, ZIP Code)		
Telephone:	Date of Birth:	<input type="checkbox"/> Visitor <input type="checkbox"/> Patient <input type="checkbox"/> Employee
Nature and Extent of Injuries: <i>(Be as specific as Possible)</i>		
<i>(Document accident description on reverse side of report)</i>		
Examined by Physician: <input type="checkbox"/> Yes <input type="checkbox"/> No		911 Called: <input type="checkbox"/> Yes <input type="checkbox"/> No
Examining Physician Name:		Transferred by EMS to:

PROPERTY LOSS/DAMAGE *(If Applicable)*

Name of Property Owner:	Telephone:
Address: (Street, City, State, ZIP Code)	<input type="checkbox"/> Visitor <input type="checkbox"/> Patient <input type="checkbox"/> Employee
Description of Property, Nature and Extent of Damages: <i>(Be as Specific as Possible)</i>	

WITNESSES

Name of Witnesses: (Last, First, Middle Initial)	Address: (Street, City, State, ZIP Code)	Telephone:
1.		
2.		
3.		
4.		

NOTE: Do not delay filing report with your general liability insurer. Keep a copy for your own records.

GENERAL LIABILITY INCIDENT REPORT (Cont'd)

Description of Accident:

Use additional space for diagrams or continuation of accident comments. Attach any available photographs. Please also include photographer's name, date and time photos taken, along with a brief description of photo written on the back of each picture.