

## GENERAL LIABILITY INCIDENT REPORT



### INSURED LOCATION

Name & Location of Incident:		Date:
Name of Employee Completing This Report:		Telephone:
Title of Employee Completing This Report:		Email:
Location of Incident:	Accident/Loss Date:	Time:

### INJURED PARTY *(If Applicable)*

Name: (Last, First, Middle Initial)		
Address: (Street, City, State, ZIP Code)		
Telephone Primary:	Date of Birth:	<input type="checkbox"/> Visitor <input type="checkbox"/> Patient <input type="checkbox"/> Employee
Secondary Phone:	Soc #:	
Nature and Extent of Injuries: <i>(Be as specific as Possible – details can be outlined on page 2)</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
DOB:	Soc #:	
Description of Property, Nature and Extent of Damages: <i>(Be as specific as Possible – details can be outlined on page 2)</i>		

### WITNESSES OR INVOLVED STAFF

Name of Witnesses: (Last, First, Middle Initial)	Role:	Contact Info:
1.		
2.		
3.		

**GENERAL LIABILITY INCIDENT REPORT** (Cont'd)

*Description of Accident or Event:*

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.