GENERAL LIABILITY

To be completed by the location administrator or business office manager for all accidents.
Please email or fax copy to:

Insurance Carrier:
Address:
Fax:

Facility Name_____

Address_____

Person Completing Report_____Position_____Date_____

Incident Description (Patient/Guest alleged) _____

_____

_____

Date of Incident_____Time_____Date facility notified_____

Location of Incident (department)_____

_____

Claimant Name_____

Address_____

City,State,Zip_____

Social Security #_____Birthdate_____ Sex _____M_____F

Home phone_____Workphone_____

Did Claimant claim injury?_____ If so, describe claimed injury_____

_____

_____

_____

Did Claimant and/or family member indicate any pre-existing medical problems or injuries? _____

If so, describe_____

_____

Ambulance called?_____ Claimant transported to_____

_____

List all medical staff present including physician's name_____

_____

List Witnesses: (All Others)

_____ _____ _____ (Name)

(Address) (Phone)

_____ _____ _____ (Name)

(Address) (Phone)