OFFICE OF RISK MANAGEMENT  
UNIT OF RISK ANALYSIS AND LOSS PREVENTION  
VISITOR/CLIENT ACCIDENT REPORTING FORM  
General Liability Claims – For Agency Use Only  

**KEEP COMPLETED FORMS ON FILE AT THE LOCATION WHERE INCIDENT/ACCIDENT OCCURRED**

(PLEASE TYPE OR PRINT)

1. AGENCY NAME and LOCATION CODE _____________________________________________
2. DATE and TIME of ACCIDENT _____________________________________________________
3. VISITOR/CLIENT NAME _________________________________________________________
4. VISITOR/CLIENT ADDRESS ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
5. CLAIMANT’S TELEPHONE # _______________________________________
6. CLAIMANT DETAIL DESCRIPTION OF HOW ACCIDENT OCCURRED
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
7. DID THE EMPLOYEE ASK THE CLAIMANT IF HE/SHE WAS INJURED?  ___Y   ___N
8. DID THE CLAIMANT VERBALLY EXPRESS AN INJURY TO ANY PART OF HIS/HER BODY?  ___Y   ___N
9. IF THE CLAIMANT EXPRESSED AN INJURY, WHAT PART OF HIS/HER BODY DID THEY STATE WAS INJURED?  PLEASE BE SPECIFIC (I.E. RIGHT FOREARM, LEFT WRIST, LOWER RIGHT ABDOMEN) ___________________________________________
   ___________________________________________________________________________________
10. IF THE CLAIMANT EXPRESSED INJURY, WAS MEDICAL CARE OFFERED?  ___Y   ___N
11. DID THE CLAIMANT ACCEPT OR DECLINE MEDICAL CARE?  ___ACCEPT   ___DECLINE
12. WERE THERE WITNESS (ES) ___Y   ___N
13. WITNESS’S NAME, ADDRESS, and TELEPHONE # (use additional sheet if needed)
   __________________________________________________
   __________________________________________________
   __________________________________________________
14. WITNESS STATEMENTS ATTACHED ___Y   ___N
15. DETAIL DESCRIPTION OF ACCIDENT LOCATION ______________________________________________________________
______________________________________________________________________________________________________________

IS THIS LOCATION IN A □ STATE-OWNED OR □ LEASED BUILDING

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

17. CHECK THE APPROPRIATE ENVIRONMENTAL CONDITION THAT IS APPLICABLE TO THE ACCIDENT: □ RAINING □ SUNNY □ CLOUDY □ FOGGY □ COLD □ HOT □ LIGHTNING □ WIND
□ OTHER WEATHER CONDITION ____________________________________________ □ WEATHER NOT A FACTOR

18. CHECK THE APPROPRIATE BOX (S) THAT PERTAINS TO THE ACCIDENT: □ LIQUID ON FLOOR—TYPE OF LIQUID ______________________ □ STAIRS □ PARKING LOT □ GARAGE □ SIDEWALK □ ELEVATORS □ GRATING
□ SPONSORED ACTIVITY □ DORMITORY □ WAITING ROOM □ WALKWAYS □ RAILINGS □ FURNITURE
□ FLOORING—DESCRIBE THE TYPE OF FLOOR AND TYPE OF WAX ______________________
□ EQUIPMENT (SPECIFY TYPE) ____________________________________________
□ OTHER CONDITION ________________________________________________

19. IF THE ACCIDENT INVOLVED ITEMS THAT CAN BE RETAINED (i.e. furniture, muffler, exam table), THE CLAIMS UNIT REQUIRES THAT THE ITEM BE TAGGED WITH THE DATE OF ACCIDENT AND NAME OF CLAIMANT. IF THE ITEM IS BROKEN OR DAMAGED, IT MUST BE PLACED IN A SECURED AREA AFTER BEING TAGGED. THE TAG CANNOT BE REMOVED OR THE BROKE/DAMAGE ITEM CANNOT BE SURPLUS/DISCARDED UNTIL NOTIFIED BY THE CLAIMS UNIT. IF APPLICABLE, WAS THIS DONE Y ___ N ___

20. WAS THE CLAIMANT AUTHORIZED TO BE IN THIS AREA ___Y ___N

21. DID ANY EMPLOYEE OBSERVE ANYTHING BEFORE/AFTER THAT IS RELEVANT TO THE ACCIDENT ___Y ___N IF YES, WAS A STATEMENT OBTAINED AND ATTACHED ___Y ___N

22. DID THE SUPERVISOR OR AGENCY SAFETY OFFICER RECEIVE A REPORT OF ANY OBSERVED CONDITIONS? ___Y ___N

23. WERE PICTURES TAKEN AND ARE THEY ATTACHED TO REPORT? Y____ N_____ 

24. NAME AND POSITION OF EMPLOYEE FILLING OUT THIS REPORT
________________________________________________
________________________________________________
________________________________________________

PLEASE DATE

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