

**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

16. DID THE PERSON CONDUCTING THE INVESTIGATION OBSERVE ANYTHING THAT WAS DIFFERENT THAN THE VISITOR'S/CLIENT'S/WITNESS'S ACCOUNT \_\_\_Y \_\_\_N IF YES, WHAT

17. CHECK THE APPROPRIATE ENVIRONMENTAL CONDITION THAT IS APPLICABLE TO THE ACCIDENT:  RAINING  SUNNY  
 CLOUDY  FOGGY  COLD  HOT  LIGHTING  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 REVELANT 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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