Florida College System Risk Management Consortium

ACCIDENT – INCIDENT REPORT

(A copy of this report is **NOT** authorization for medical treatment)

INSTRUCTIONS:

- If loss/occurrence/injury is to a **college employee**, please complete sections: 1, 2, 5, 6, 7 and 8.
- If loss/occurrence is to **college-owned property** please complete sections: 1, 3, 5, 6, 7 and 8.
- If loss/occurrence/injury is to a **non college employee or non college-owned property**, please complete sections: 1, 4, 5, 6, 7 and 8.

1. LOCATION AND DATE OF INCIDENT/OCCURRENCE

COLLEGE: (Check One)

☐ **BC**	☐ **FGC**	☐ **IRSC**	☐ **PBSC**	☐ **SJRSC**	☐ **TCC**	CAMPUS/LOCATION CODE:
☐ **CC**	☐ **CFK**	☐ **LSSC**	☐ **PHCC**	☐ **SPC**	☐ **VC**	
☐ **CCF**	☐ **FSWSC**	☐ **MDC**	☐ **PeSC**	☐ **SSC**		
☐ **DSC**	☐ **GCSC**	☐ **NFCC**	☐ **PoSC**	☐ **SFSC**		
☐ **EFSC**	☐ **HCC**	☐ **NWFSC**	☐ **SFC**	☐ **SCFMS**		

DATE OF OCCURRENCE:	TIME OF OCCURRENCE: AM PM	LOCATION OF OCCURRENCE (BE SPECIFIC):

2. INJURED EMPLOYEE (INJURY/LOSS TO COLLEGE EMPLOYEE)

NAME OF EMPLOYEE:	AGE:	OCCUPATION & DEPARTMENT:	EMPLOYEE #:

ADDRESS:	CITY:	ST:	ZIP:

PHONE: ( )	PART OF BODY INJURED:	TYPE OF INJURY (CUT, STING, BUMP, BRUISE ETC.):

DOES EMPLOYEE WISH TO SEEK MEDICAL ATTENTION TODAY: ☐ YES ☐ NO*	WILL EMPLOYEE REQUIRE TIME OFF FROM WORK: ☐ YES ☐ NO	DATE INJURY FIRST REPORTED:	TIME INJURY FIRST REPORTED:

* A "no" answer does not waive the employee's right to request medical attention at a later date.

3. PROPERTY (COLLEGE OWNED)

IDENTIFY THE DAMAGED/LOST PROPERTY:	ESTIMATED COST OF DAMAGED/LOST PROPERTY: $

4. INJURED PARTY/PROPERTY (PERSONS NOT EMPLOYEED BY COLLEGE AND/OR PROPERTY NOT OWNED BY COLLEGE)

NAME:	AGE:	PHONE: ( )	

ADDRESS:	CITY:	ST:	ZIP:

IDENTIFY THE INJURY OR THE DAMAGED/LOST PROPERTY:	STUDENT ID # (If Injured Party is Admitted Student):

5. WITNESS(ES)

NAME:	PHONE: ( )		
ADDRESS:	CITY:	ST:	ZIP:

NAME:	PHONE: ( )		
ADDRESS:	CITY:	ST:	ZIP:

Revised: 01/20

6. DESCRIBE THE LOSS/OCCURRENCE/INJURY (To be completed by Injured Employee/Party, if at all possible):

7. SIGNATURES

INJURED EMPLOYEE/PARTY'S SIGNATURE: DATE:

DEPARTMENT CONTACT'S SIGNATURE: DATE:

8. RISK MANAGEMENT COORDINATOR REVIEW (To be completed by the College's Risk Management Coordinator):

TYPE OF CLAIM (Please Check One):

☐ GENERAL LIABILITY	☐ STUDENT ACCIDENT
☐ COLLEGE PROPERTY DAMAGE/THEFT	☐ ATHLETIC
☐ EQUIPMENT BREAKDOWN	☐ FACILITIES USE
☐ WORKER'S COMPENSATION**	☐ ALLIED HEALTH (Please Attach Allied Health Incident Form)

** Please do not send Work Comp A/I forms to the Consortium. The College WC coordinator should submit all WC claims through the call center.

RISK MANAGEMENT REVIEW STATEMENTS (Initial **ONLY** those statements that apply):

_____ THIS A/I IS **FYI ONLY.** NO CLAIM IS BEING SUBMITTED AT THIS TIME.

_____ THIS A/I HAS BEEN SUBMITTED TO A-G ADMINISTRATORS, FOR CLAIM REVIEW (Student Accident Coverage).

_____ THIS A/I HAS BEEN SUBMITTED TO Relation Insurance, FOR CLAIM REVIEW (Athletic Coverage).

RISK MANAGEMENT COORDINATOR'S SIGNATURE: DATE:

Revised: 01/20