General liability INCIDENT REPORT

To report an incident, please complete the form and send to Brandon Rothkopf, brandonrothkopf@archstl.org, 314-792-7079 (fax)

***Note: Any question with an asterisk (\*) is required information.***

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| **Client Information** |
| \*GB Client Number | 000292 |
| \*Client Name | Archdiocese of St. Louis |
| **Date and Time** |
| \*Incident Date | Enter date.  |
| \*Insured Notified Date | Enter date. |
| **Client Location** |
| \*Location Code | Enter Location Code. |
| \*Name | Enter Name. |
| Street Address | Enter Street Address. |
| City | Enter City. | \*State | Choose State. | ZIP | Enter ZIP. |
| Phone Number | Enter phone #. |  |
| **Submitter Information** |
| Name | Enter Name. |
| Title | Enter Title. |
| Email Address | Enter Email. |
| Phone Number | Enter Phone #. |
| **Incident Information** |
| \* Detailed Description of Incident (Limit the description field 250 characters) | Enter Description. |
| **Witnesses** *(Only if any Witnesses) - can add as many as necessary* |
| First Name | Enter First Name. | Last Name | Enter Last Name. |
| Home Phone | Enter Phone #. | Work Phone | Enter Phone #. |
| **Location of Incident** *(type SAME, if same as reporting location)* |
| Location Name | Enter Location Name. |
| Street Address | Enter Street Address. |
| City | Enter City. | \*State | Choose State. | ZIP | Enter ZIP. |
| **Authority** |
| Authority Name (e.g. police officer) | Enter Name. |
| Phone Number | Enter Phone #. |
| **Involved Parties** *(can add as many as necessary)* |
| \*First Name | Enter Name. | Middle Initial | Enter Initial. |
| \*Last Name | Enter Name. |  |
| Phone Number | Enter Phone #. |
| Street Address | Enter Street Address. |
| City | Enter City. | State | Choose State. | ZIP | Enter ZIP. |
| Birth Date | Enter date. | Date of Death (if applicable) | Enter date. |
| Marital Status | Choose... | Gender | Choose... |
| Relationship to Client (employee, spouse, self, customer, unknown, other) | Enter text. |
| **Medical Provider** *(Only if medical treatment rendered)* |
| Hospital/Clinic Name | Enter text. |
| Street Address | Enter Street Address. |
| City | Enter City. | State | Choose State. | ZIP | Enter ZIP. |
| Phone Number | Enter Phone #. |
| Doctor Name | Enter Name. |
| Street Address | Enter Street Address. |
| City | Enter City. | State | Choose State. | ZIP | Enter ZIP. |
| Phone Number | Enter Phone #. |
| **Involved Party Employer**  |
| Name | Enter Name. |
| Work Phone | Enter Phone #. |
| Occupation | Enter text. |
| Involvement Type (claimant or owner; owner refers to property) | Enter text. |
| **Property** *(if applicable)* |
| Third Party Property? | Choose... |
| Describe Item(s) | Enter text. |
| Damage Description | Enter text. |
| Estimated Damage | Enter text. |
| Insurance Co. Name | Enter text. |
| Policy Number | Enter text. |

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| **When/Where Can Be Seen** *(current location of property)* |
| Name | Enter Name. |
| Street Address | Enter Street Address. |
| City | Enter City. | State | Choose State. | ZIP | Enter ZIP. |
| When | Enter text. | Owner | Enter text. |
| **Notes/Additional Comments** *(ie, if this is for report only)* |
| Additional Remarks | Enter text. |