GENERAL LIABILITY LOSS REPORT

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| --- | --- | --- |
| Department of Financial Services |  |  |
| Division of Risk Management |  |  |
| State Liability Claims |  |  |
| Larson Building |  |  |
| Tallahassee, FL 32399-0338 | RM File No.: |  |

(Do not complete)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **INSURED AGENCY** |  | Department: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | Division and Location: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | |
|  | Bureau, Institution, or District: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **ACCIDENT** |  | |  | Date: | | | |  | | | | | | |  | Time: | |  | | | | | |  | | Location: | |  | | | | |  |
|  | | Type of Claim: | | | | |  | Bodily Injury: | | | | | | | |  |  | | | |  | Property Damage: | | | |  |  | | |  |  | |
|  | |  | | | | | | | Medical Malpractice: | | | | | | |  |  | | | |  | Other: | | | |  |  | | |  |  | |
|  | | Description: | | |  | |  | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| INJURED **PERSON** |  | | Name: | |  | | | | | | | | | | | | | |  | Age: |  | | |  | Telephone No.: | | | |  | | |  | |
|  | | Address: | |  | | | | | | | | | | | | | |  | City: |  | | | | | | | | State: |  | |  | |
|  | | Occupation & Employer: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
|  | | Why on Premises: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
|  | | Nature & Extent of Injury: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
|  | |  | | | | | | | | | | (List additional injured persons on back of form.) | | | | | | | | | | | | | | | | | | |  | |
| **PROPERTY DAMAGE** |  | | Owner & Address: | | | | | | | |  | | | | | | | | | | | | | | Telephone No.: | | | |  | | |  | |
|  | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | |
|  | | Description of Property: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | |
|  | | Describe Damage: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | |
|  |  | | When & where can property be inspected: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | |

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|  |  |  | | | | | | | | | |  |
| **WITNESSES** |  | Name | |  | Address | | | | |  | Telephone No. |  |
|  |  | |  |  | | | | |  |  |  |
|  |  | |  |  | | | | |  |  |  |
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|  |  | |  |  | | | | |  |  |  |
| POLICE **REPORT** |  | Identify Police Authority Investigating: | | | | |  | | | | |  |
|  | Their Location: |  | | | | | | | | |  |
|  |  | | | | | | | | | |  |
|  |  | (USE BACK FOR ADDITIONAL COMMENTS) | | | | | | | | | |  |
|  | | | | | |  | |  |  | | | |
| Date of Report | | | | | |  | |  | Signature of person filing report | | | |
|  | | | | | |  | |  |  | | | |
|  | | | | | |  | |  | Telephone No.: | | | |

*(List additional injured persons here.)*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **INJURED PERSON** |  | Name: |  | |  | Age: |  |  | Telephone No.: |  | |  |
|  | Address: |  | |  | City |  |  | State: |  | |  |
|  | Occupation & Employer: | |  | | | | | | |  | |
|  | Why on Premises: | |  | | | | | | |  | |
|  | Nature & Extent of Injury: | |  | | | | | | |  | |
|  |  | | | | | | | | |  | |
| **INJURED PERSON** |  | Name: |  | |  | Age: |  |  | Telephone No.: |  | |  |
|  | Address: |  | |  | City |  |  | State: |  | |  |
|  | Occupation & Employer: | |  | | | | | | |  | |
|  | Why on Premises: | |  | | | | | | |  | |
|  | Nature & Extent of Injury: | |  | | | | | | |  | |
|  |  | | | | | | | | |  | |
| **INJURED PERSON** |  | Name: |  | |  | Age: |  |  | Telephone No.: |  | |  |
|  | Address: |  | |  | City |  |  | State: |  | |  |
|  | Occupation & Employer: | |  | | | | | | |  | |
|  | Why on Premises: | |  | | | | | | |  | |
|  | Nature & Extent of Injury: | |  | | | | | | |  | |
|  |  | | | | | | | | |  | |
| ADDITIONAL COMMENTS: | | | | | | | | | | | | |
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