GENERAL LIABILITY LOSS REPORT

Department of Financial Services
Division of Risk Management
Bureau of State Liability Claims
Larson Building
Tallahassee, FL 32399-0338

RM File No.: _____
(Do not complete)

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: _____
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: _____
WITNESSES	Name _____ Address _____ Telephone No. _____ _____ _____ _____ _____ _____ _____
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.)

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: