

WORKSHEET FOR LIABILITY TELEPHONE REPORTING

ACCOUNT INFORMATION

TELEPHONE NUMBER & EXTENSION	REPORTED BY <input type="checkbox"/> ACCOUNT <input type="checkbox"/> CLAIMANT <input type="checkbox"/> PRODUCER
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CALLER'S NAME (FIRST, MIDDLE, LAST AND TITLE)

PRODUCT LIABILITY (ONLY) Company Headquarters Located in what State _____	SLIP & FALL OR OTHER LIABILITY (ONLY) Accident Occurred in what State _____
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Complete the following for ALL LIABILITY CLAIMS

BUSINESS NAME, ADDRESS, DEPARTMENT	MAILING ADDRESS (IF DIFFERENT)
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IF ACCIDENT OCCURRED AT DIFFERENT ADDRESS, PROVIDE ADDRESS (INCLUDE SPECIFICS E.G., AISLE OF FALL, DEPT., ETC.)

ACCIDENT INFORMATION

DATE AND TIME OF ACCIDENT _____ _____ PM _____ AM	DETAILED DESCRIPTION OF ACCIDENT
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Complete the following for PRODUCT LIABILITY CLAIMS

PRODUCT DESCRIPTION	HOW WAS PRODUCT BEING USED				
MANUFACTURER'S NAME	MAKE	MODEL	SIZE	STYLE	SERIAL NO. AND/OR PRODUCT I.D. NO
WAS THERE DAMAGE TO PRODUCT?	WHERE AND WHEN WAS PRODUCT PURCHASED?		WHERE AND WHEN MAY PRODUCT BE SEEN?		

Complete the following for SLIP & FALL CLAIMS

WHAT SUBSTANCE OR OBJECT CAUSED CLAIMANT TO SLIP, TRIP, OR FALL?	HOW DID SUBSTANCE OR OBJECT GET THERE?
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Complete the following for ALL LIABILITY CLAIMS

WERE THERE ANY WITNESSES? <input type="checkbox"/> YES <input type="checkbox"/> NO	WITNESS NAME	WITNESS ADDRESS
HOME PHONE NO.	BUSINESS PHONE NO.	BEST TIME & PLACE TO CONTACT WITNESS
WHERE WAS WITNESS AT TIME OF ACCIDENT?	RELATIONSHIP OF WITNESS TO PARTIES INVOLVED?	
Any other witness? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" provide name, address & phone no.)		

Were authorities contacted? YES NO (If "YES" complete the following)

NAME OF AUTHORITY (AMBULANCE, POLICE, FIRE, ETC.)	AUTHORITY ADDRESS
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REPORT NUMBER (IF AVAILABLE)	VIOLATIONS OR CITATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" describe)
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NATURE OF OCCURRENCE

- WERE THERE COMPLAINTS OF INJURIES (any medical treatments)? YES NO
- If "YES" complete "INJURIES" Section on back of form.
- WAS THERE ANY DAMAGE TO PROPERTY YOU DO NOT OWN? YES NO
- If "YES" complete "PROPERTY DAMAGE" Section on back of form.

INJURIES

NAME (FIRST, MIDDLE, LAST)		ADDRESS	
HOME PHONE NUMBER	BUSINESS PHONE NUMBER	OCCUPATION	DATE OR BIRTH OR AGE
SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DESCRIPTION OF INJURY	
Was Medical Treatment Received? <input type="checkbox"/> YES <input type="checkbox"/> NO (If so, from whom)			
NAME OF HOSPITAL/CLINIC/DOCTOR		ADDRESS OF HOSPITAL/CLINIC/DOCTOR	PHONE NUMBER
TYPE OF TREATMENT	LENGTH OF STAY	SPECIALTY OF DOCTOR	FIRST DAY OF TREATMENT
Is injured represented by an attorney? <input type="checkbox"/> YES <input type="checkbox"/> NO Was Lawsuit Served? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" Date)			
NAME OF ATTORNEY		ADDRESS OF ATTORNEY	ATTORNEY PHONE NUMBER
EMPLOYER NAME	EMPLOYER ADDRESS		EMPLOYER PHONE NUMBER

*** If multiple injuries repeat above section

PROPERTY DAMAGE INFORMATION

OWNER'S NAME (FIRST, MIDDLE, LAST)		OWNER'S ADDRESS	
HOME PHONE NO.	BUSINESS PHONE NO.	DESCRIPTION OF ITEM DAMAGED AND DESCRIBE DAMAGE TO ITEM	ESTIMATE OF DAMAGE

*** If other property damage repeat above section

ACCOUNT CONTACT INFORMATION

BEST PERSON TO CONTACT FOR MORE INFORMATION	WHERE	TIME	PHONE NO.
ADDITIONAL COMMENTS AND CUSTOMER SPECIFIC INFORMATION			