

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	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%; text-align: center;">Name</th> <th style="width: 33%; text-align: center;">Address</th> <th style="width: 33%; text-align: center;">Telephone No.</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Name	Address	Telephone No.	_____	_____	_____	_____	_____	_____	_____	_____	_____
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.:

