GENERAL LIABILITY REPORT FORM

Date of Loss	
Time of Loss	☐ AM ☐ PM
Exact Location	
Department	
Authority Contacted	
Report # (attach if available)	

Employee Information (if involved)

Employee Name	
SSN (Last 4 Digits)	
Job Title	
Department/Subdivision	/
Supervisor	
Workers Compensation claim also filed?	☐ Yes ☐ No
If yes, please describe injuries	
Was the employee cited?	☐ Yes ☐ No
If yes, please describe	

Reporting

Person Notified	
Date and Time Notified	/ / : ☐ AM ☐ PM

Description of Loss

Detailed Description of How Loss Occurred	
Detailed Description of Property Damage	
Where Can Property Be Seen?	
Detailed Description of Any Injuries Claimed	
Witnesses Names and Phone Numbers	______ ______ ______

General Liability Form

Other Claims Filed in Addition to This Claim

Auto	☐ Yes ☐ No
Property	☐ Yes ☐ No
Workers Compensation	☐ Yes ☐ No

Other Information

Was the loss a result of any malfunction or defect of a product?	☐ Yes ☐ No
If yes, please describe (**IMPORTANT**: please retain all evidence until investigation is complete)	
Other Parties Involved	☐ Yes ☐ No
If yes, please provide names and phone numbers of other parties	_____ _____
Was medical attention sought by any party?	☐ Yes ☐ No
If yes, where?	
Was a County vehicle involved?	☐ Yes ☐ No
If yes, provide the following information:	VIN #: _____ Make: _____ Model: _____ Year: _____

Reported by: _____

Comments: _____

Complete this form and submit to Human Resources within 24 hours of the loss.

General Liability Form

Complete all fields if the information is available.
Contact Human Resources at 814-6402 with questions.