IMPORTANT!!

Report all accidents, injuries, and property losses to:

Gallagher Bassett
877-376-2561

Toll free claims reporting number is in operation 24 HOURS A DAY, 7 DAYS A WEEK.

You may need our client ID which is: **060005**

Any incident involving multiple people or death must be reported IMMEDIATELY to the Diocesan Risk & Insurance Manager
(941) 486-4732
insurance@dioceseofvenice.org

ACCIDENT/INCIDENT CHECKLIST

- 1. Call 911 if Medical Emergency.

- 2. Secure the Scene to ensure no further injury is likely to occur, then when safer to do so render First Aid if trained.

- 3. When appropriate use a camera to capture pictures of accident/incident scene in all quadrants.

- 4. If injured party does not need Emergency Care but requires further medical attention refer them to the nearest in-network Walk-In or Urgent Care provider.

- 5. Complete Accident/Injury Reporting Notes, be as detailed as possible.

- 6. Call Gallagher Bassett and report the incident. Incidents should be reported on the day they occurred.
  If there is any question if the incident should be reported to insurance or not, contact the Diocesan Risk & Insurance Manager at the Catholic Center.

- 7. Any incident involving multiple individuals or an employee death must be reported immediately to the Risk Manager at the Catholic Center.

Diocese of Venice
Accident/Injury Reporting Notes

Upon Completion **Call**: Gallagher Basset Claims Reporting 877-376-2561

INSTRUCTIONS: ALL MUST COMPLETE SECTIONS 1 & 2...

Worker's Compensation claim, complete sections 3,6,7 and 8 below. (3A and 3B must be completed).
Student Accident/Incident, Visitor Accident/Incident or Volunteer Accident/Incident, complete sections 4,6,7 and 8 below.
Auto or Church Property Claim, complete sections 5,6,7 and 8 below (as appropriate).

Note: A copy of this report is not authorization for medical treatment.

Please Print

1. SCHOOL/PARISH NAME

School/Parish/Agency	☐Work. Comp ☐Student Accident ☐Prop Loss ☐Auto ☐Visitor Accident/Incident	Person Injured: ☐Employee ☐ Visitor ☐Student ☐ Volunteer	Social Security No.

2. ACCIDENT

Date of Loss: MM/DD/YY / /	Time of Loss: : ☐ a.m. ☐ p.m.	Location of Loss (Be specific)

3. EMPLOYEE (WORKERS' COMPENSATION CLAIMS)

Name of Employee:	Date of Birth: / /	Occupation & Organization:	Part of Body Injured:	Type of injury (Cut, Bruise, Etc.)
Home Address:	**City:**	**State:**	**Zip:**	**Phone No. ( )**

3A-Does Employee wish to seek medical attention today: ☐Yes ☐No A "No" answer above does not waive the employee's right to request medical attention at a later date.	If "Yes", Designate referral (Name of Physicians, Clinic, Hospital):	3B-Will Employee require time off from work: ☐Yes ☐No	Expected return to work date:

4. CLAIMANT (Student Accident/Incident, Visitor Accident/Incident or Volunteer Accident/Incident)

Name:	Date of Birth: / /	Time injury first reported:		
Address:	**City:**	**State:**	**Zip:**	**Phone No. ( )**

5. PROPERTY (CHURCH OWNED) Attach picture of damaged or stolen property, Police and/or Public Safety report

Describe damaged or stolen property:	
	Estimated cost of damage or value of stolen item:

6. WITNESS (ES)

Name:	Address:	City:	State:	Zip:	Phone No. ( )
Name:	**Address:**	**City:**	**State:**	**Zip:**	**Phone No. ( )**

7. DESCRIBE ACCIDENT/INCIDENT ***(To be completed by claimant. If claimant is unable to write, ask the following questions then write their response.)***

A. What were you doing when injury/loss occurred?

B. How did the injury/loss occur?

C. Object or substance that , in your opinion, directly injured or caused loss?

8. SIGNATURES

Signature of Employee/Claimant: Date: / /	Signature of Entity Representative: Date: / /

Keep the ORIGINAL DOCUMENT on file at your location

May 2012

Voluntary Statement

Name: (Last, First)_____

Street Address: _____
City, State, Zip: _____

Phone: _____

Date / Time: _____

Location Where Statement is Made: _____

Details of Occurance:

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(Attach Additional Pages if Necessary - # of pages _____)
I certify that the facts contained herein are true and correct to the best of my knowledge.

Signature of Person Making the Statement: _____

Voluntary Witness Statement

Name: (Last, First)_____

Street Address: _____
City, State, Zip: _____

Phone: _____

Date / Time: _____

Location Where Statement is Made: _____

Details of Occurance:

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