

# INCIDENT FORM

Office of Risk Management - 103 Rider Building - 227 W. Beaver Ave. - State College, PA 16801

(814) 863-5539 FAX (814) 865-4029

DO NOT use this form for Workers' Compensation or automobile accident claims.

<b>TIME &amp; PLACE OF ACCIDENT/ INCIDENT</b>	Date: _____ Time: _____ Location: _____ City: _____ State: _____ Zip Code: _____		
<b>PROPERTY DAMAGE</b>	Owner: _____ Phone #: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Email Address: _____		
<b>INJURED PERSON</b>	Name: _____ Age: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Email Address: _____ Occupation: _____ Nature of Injury: _____ Injured taken to: _____		
<b>WITNESSES</b>	NAME:	ADDRESS:	PHONE #:
	_____	_____	_____
	_____	_____	_____
<b>FACTORS</b>	Premises: <input type="checkbox"/> dry <input type="checkbox"/> wet <input type="checkbox"/> snow covered <input type="checkbox"/> icy <input type="checkbox"/> other: _____ Surface: <input type="checkbox"/> concrete <input type="checkbox"/> asphalt <input type="checkbox"/> metal <input type="checkbox"/> carpet <input type="checkbox"/> tile <input type="checkbox"/> other: _____ Lighting: <input type="checkbox"/> indoor - on <input type="checkbox"/> indoor - off <input type="checkbox"/> outdoor - sunny <input type="checkbox"/> outdoor - overcast <input type="checkbox"/> other: _____		
<b>DESCRIBE INCIDENT FACTS IN DETAIL</b>			
USE A SEPARATE SHEET OF PAPER IF NECESSARY			

**Students Only:** I hereby grant authorization to The Pennsylvania State University to release this Incident Form to its insurance carrier(s) if warranted for their use in evaluating a claim.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Report Taken By: \_\_\_\_\_ Date: \_\_\_\_\_

**Completed form must be forwarded immediately to Risk Management Claims Supervisor.**