# General Liability Loss Report Form

## Instructions:

- This form is to be completed for all incidents involving students and visitors – both injury and non-injury related.
- Upon completion, please forward to the Facilities Manager for review by the Dean's office, and submission to Risk Management.

# 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: UNIVERSITY OF SOUTH FLORIDA<br>Division and Location: 4202 E. Fowler Ave., CRS 104, Tampa FL 33620<br>Bureau, Institution, or District: ______ |
| **ACCIDENT** | Date: ______ Time: ______ Location: ______<br>Type of Claim: Bodily Injury: ______ Property Damage: ______<br>Medical Malpractice: ______ Other: ______<br>Description: ______ |
| **INJURED PERSON** | Name: ______ Age: ______ Telephone No.: ______<br>Address: ______ City: ______ State: ______<br>Occupation & Employer: ______<br>Why on Premises: ______<br>Nature & Extent of Injury: ______<br>(List additional injured persons on back of form.) |
| **PROPERTY DAMAGE** | Owner & Address: ______ Telephone No.: ______<br>Description of Property: ______<br>Describe Damage: ______<br>When & where can property be inspected: ______ |
| **WITNESSES** | Name / Address / Telephone No. |
| **POLICE REPORT** | Identify Police Authority Investigating: ______<br>Their Location: ______ |

(USE BACK FOR ADDITIONAL COMMENTS)

______________________
Date of Report

______________________
Signature of person filing report

______________________
Telephone No.:

*(List additional injured persons here.)*

| | |
|---|---|
| **INJURED PERSON** | Name: ______ Age: ______ Telephone No.: ______<br>Address: ______ City ______ State: ______<br>Occupation & Employer: ______<br>Why on Premises: ______<br>Nature & Extent of Injury: ______ |
| **INJURED PERSON** | Name: ______ Age: ______ Telephone No.: ______<br>Address: ______ City ______ State: ______<br>Occupation & Employer: ______<br>Why on Premises: ______<br>Nature & Extent of Injury: ______ |
| **INJURED PERSON** | Name: ______ Age: ______ Telephone No.: ______<br>Address: ______ City ______ State: ______<br>Occupation & Employer: ______<br>Why on Premises: ______<br>Nature & Extent of Injury: ______ |

ADDITIONAL COMMENTS: