

Instructions: All must complete Sections 1, 2, 6, 8, & 9

**Worker's Compensation claim**, complete section 3 **General Liability / Premises Liability**, complete section 4 **Property Claim**, complete section 5

**Auto Liability Claim**, complete section 7

Please Print: (To be completed by authorized personnel)

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| **1. Location Information** | | | | | | | |
| **Location Name / Number:** | | **Physical Address:** | | | | * Workers Compensation  * Visitor Accident / Incident * Property Loss | |
| **2. Accident** | | | | | | | |
| **Date of Loss:** | **Time of Loss:** | | | **Location of Loss (i.e., Our Lady of Mercy Parking Lot):** | | | |
| **3. Employee (Workers' Compensation Claims)** | | | | | | | |
| **Name of Injured Employee:** | | **Date of Birth:** | | **Job Title:** | | | **Does employee require time off of**  **work? □ Yes □ No** |
| **Social Security #:** | | **Date of Hire:** | | **Marital Status:** | |  | |
| **Home Address:** | | **City:** | | **State** | **Zip:** | | **Home Number:** |
| **Cell Number:** |
| **4. General Liability / Premises Liability** | | | | | | | |
| **Name of Injured Party or Owner of Damaged Property:** | | | **Date of Birth:** | | **Phone Number:** | | |
| **Home Address:** | | **City:** | | **State:** | **Zip:** | | **Alternate Phone Number:** |
| **5. Property** | | | | | | | |
| **Describe damaged or stolen property and how loss occured:** | | | | | | | |
| **Estimated cost of damage or value of stolen item: (attach all pictures, police reports, and/or estimates)** | | | | | | | |
| **6. Witness(es) (Please have witness(es) provide a written statement if possible)** | | | | | | | |
| **Name of Witness:** | | | | | | | |
| **Home Address:** | | **City:** | | **State** | **Zip:** | | **Phone Number:** |
| **Name of Witness:** | | | | | | | |
| **Home Address:** | | **City:** | | **State** | **Zip:** | | **Phone Number:** |

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| **7. Auto Liability** | | | | | | | |
| Diocese Driver Information | | | | | | | |
| **Last Name:** | | | **First Name:** | | | | |
| **Address:** | | | | | | | |
| **Contact Number:** | | | **D/L Number:** | | | | |
| **Date of Birth:** | | | **Years with Company:** | | | | |
|  | | | | | | | |
| Diocese Vehicle Information | | | | | | | |
| **Year:** | **Make:** | | | **Model:** | | | |
| **Vehicle VIN:** | | **Damage Description:** | | | | | |
|  | | | | | | | |
| Claimant Vehicle 1 | | | | | | | |
| **Year:** | **Make:** | | | **Model:** | | |  |
| **Description of Damages:** | | | | | | | |
| **Location Where Vehicle Can be Seen:** | | | | | | | |
| Driver of Vehicle 1 | | | | | | | |
| **Last Name:** | | | **First Name:** | | | | |
| **Address:** | | | | | | | |
| **Contact Number:** | | | | | **Injured:** | * Yes | * No |
| Owner of Vehicle 1 (If Different than Driver) | | | | | | | |
| **Last Name:** | | | **First Name:** | | | | |
| **Address:** | | | | | | | |
| **Contact Number:** | | | | | **Injured:** | * Yes | * No |
| Claimant Vehicle 2 | | | | | | | |
| **Year:** | **Make:** | | | **Model:** | | |  |
| **Description of Damages:** | | | | | | | |
| **Location Where Vehicle Can be Seen:** | | | | | | | |
| Driver of Vehicle 2 | | | | | | | |
| **Last Name:** | | | **First Name:** | | | | |
| **Address:** | | | | | | | |
| **Contact Number:** | | | | | **Injured:** | * Yes | * No |
| Owner of Vehicle 2 (If Different than Driver) | | | | | | | |
| **Last Name:** | | | **First Name:** | | | | |
| **Address:** | | | | | | | |
| **Contact Number:** | | | | | **Injured:** | * Yes | * No |
|  | | | | | | | |
| Property Damage other than a Vehicle: | | | | | | | |
| **Description of Property:** | | | | | | | |
| **Description of Damage:** | | | | | | | |
| Scene Diagram: | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **8. Accident / Incident** | | | | | | |
| **Date / Time reported:** | | **Reported by (name):** | | | **Reported to (name):** | |
| **If injury occurred, type of injury (cut, bruise, etc...)** | | **Part(s) of body injured:** | | |  | |
| **Did injured party seek medical treatment since accident**  □ Yes □ No □ Unknown | | **If "Yes", name of physician, clinic, or hospital (If known):** | | | | |
| **Was first aid administered on-site:**  □ Yes □ No | **If "Yes", who administered first aid:** | | | **Type of first aid administered: (CPR, bandage, icepack, etc...)** | | |
| **Description of accident:** | | | | | | |
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| Officials Called to Scene: | * Police | * Fire | * EMS |  |  |  |
| Municipality: | | | | Report Number: | | |
|  | | | | | | |
| **9. Signature of Authorized Personnel Completing Report** | | | | | | |
| Print Name & Job Title (Position): | | Signature: | | | | Date: |
| Home Address: | | City: | | State | Zip: | Contact Number: |

Retain original for Location files

**Submit copy to Diocese of Baton Rouge, Risk Manager, Eric Raby** [**eraby@diobr.org**](mailto:eraby@diobr.org)

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