

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

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| **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:** |
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| Diocese Vehicle Information |
| **Year:** | **Make:** | **Model:** |
| **Vehicle VIN:** | **Damage Description:** |
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| 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

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| 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

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| Owner of Vehicle 2 (If Different than Driver) |
| **Last Name:** | **First Name:** |
| **Address:** |
| **Contact Number:** | **Injured:** | * Yes

 | * No

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| 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: |
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| **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**

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