

Florida College System Risk Management Consortium

ACCIDENT – INCIDENT REPORT

(A copy of this report is **NOT** authorization for medical treatment)

INSTRUCTIONS:

- If loss/occurrence/injury is to a **college employee**, please complete sections: 1, 2, 5, 6, 7 and 8.
- If loss/occurrence is to **college-owned property** please complete sections: 1, 3, 5, 6, 7 and 8.
- If loss/occurrence/injury is to a **non college employee or non college-owned property**, please complete sections: 1, 4, 5, 6, 7 and 8.

1. LOCATION AND DATE OF INCIDENT/OCCURRENCE

COLLEGE: (Check One)

<input type="checkbox"/> BC	<input type="checkbox"/> EFSC	<input type="checkbox"/> IRSC	<input type="checkbox"/> PBSC	<input type="checkbox"/> SJRSC	<input type="checkbox"/> TSC	CAMPUS/LOCATION CODE:
<input type="checkbox"/> CC	<input type="checkbox"/> FGC	<input type="checkbox"/> LSSC	<input type="checkbox"/> PHSC	<input type="checkbox"/> SPC	<input type="checkbox"/> VC	
<input type="checkbox"/> CF	<input type="checkbox"/> FSWSC	<input type="checkbox"/> MDC	<input type="checkbox"/> PeSC	<input type="checkbox"/> SSC		
<input type="checkbox"/> CFK	<input type="checkbox"/> GCSC	<input type="checkbox"/> NFC	<input type="checkbox"/> PoSC	<input type="checkbox"/> SFSC		
<input type="checkbox"/> DSC	<input type="checkbox"/> HC	<input type="checkbox"/> NWFSC	<input type="checkbox"/> SFC	<input type="checkbox"/> SCFMS		

DATE OF OCCURRENCE:	TIME OF OCCURRENCE: AM PM	LOCATION OF OCCURRENCE (BE SPECIFIC):
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2. INJURED EMPLOYEE (INJURY/LOSS TO COLLEGE EMPLOYEE)

NAME OF EMPLOYEE:	AGE:	OCCUPATION & DEPARTMENT:	EMPLOYEE #:
ADDRESS:	CITY:	ST:	ZIP:
PHONE: ()	PART OF BODY INJURED:	TYPE OF INJURY (CUT, STING, BUMP, BRUISE ETC.):	
DOES EMPLOYEE WISH TO SEEK MEDICAL ATTENTION TODAY: <input type="checkbox"/> YES <input type="checkbox"/> NO*	WILL EMPLOYEE REQUIRE TIME OFF FROM WORK: <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE INJURY FIRST REPORTED:	TIME INJURY FIRST REPORTED:

* A "no" answer does not waive the employee's right to request medical attention at a later date.

3. PROPERTY (COLLEGE OWNED)

IDENTIFY THE DAMAGED/LOST PROPERTY:	ESTIMATED COST OF DAMAGED/LOST PROPERTY: \$
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4. INJURED PARTY/PROPERTY (PERSONS NOT EMPLOYED BY COLLEGE AND/OR PROPERTY NOT OWNED BY COLLEGE)

NAME:	AGE:	PHONE: ()
ADDRESS:	CITY:	ST: ZIP:
IDENTIFY THE INJURY OR THE DAMAGED/LOST PROPERTY:		STUDENT ID # (If Injured Party is Admitted Student):

5. WITNESS(ES)

NAME:	PHONE: ()
ADDRESS:	CITY: ST: ZIP:
NAME:	PHONE: ()
ADDRESS:	CITY: ST: ZIP:

6. DESCRIBE THE LOSS/OCCURRENCE/INJURY (To be completed by Injured Employee/Party, if at all possible):					

7. SIGNATURES	
INJURED EMPLOYEE/PARTY'S SIGNATURE:	DATE:
DEPARTMENT CONTACT'S SIGNATURE:	DATE:

DATE:

DATE:

8. RISK MANAGEMENT COORDINATOR REVIEW (To be completed by the College's Risk Management Coordinator):	
TYPE OF CLAIM (Please Check One):	
<input type="checkbox"/> GENERAL LIABILITY <input type="checkbox"/> COLLEGE PROPERTY DAMAGE/THEFT <input type="checkbox"/> EQUIPMENT BREAKDOWN <input type="checkbox"/> WORKER'S COMPENSATION**	<input type="checkbox"/> STUDENT ACCIDENT <input type="checkbox"/> ATHLETIC <input type="checkbox"/> FACILITIES USE <input type="checkbox"/> ALLIED HEALTH (Please Attach Allied Health Incident Form)

TYPE OF CLAIM (Please Check One):	
<input type="checkbox"/> GENERAL LIABILITY <input type="checkbox"/> COLLEGE PROPERTY DAMAGE/THEFT <input type="checkbox"/> EQUIPMENT BREAKDOWN <input type="checkbox"/> WORKER'S COMPENSATION**	<input type="checkbox"/> STUDENT ACCIDENT <input type="checkbox"/> ATHLETIC <input type="checkbox"/> FACILITIES USE <input type="checkbox"/> ALLIED HEALTH (Please Attach Allied Health Incident Form)

- | | |
|--|--|
| <input type="checkbox"/> GENERAL LIABILITY | <input type="checkbox"/> STUDENT ACCIDENT |
| <input type="checkbox"/> COLLEGE PROPERTY DAMAGE/THEFT | <input type="checkbox"/> ATHLETIC |
| <input type="checkbox"/> EQUIPMENT BREAKDOWN | <input type="checkbox"/> FACILITIES USE |
| <input type="checkbox"/> WORKER'S COMPENSATION** | <input type="checkbox"/> ALLIED HEALTH (Please Attach Allied Health Incident Form) |

**** Please do not send Work Comp A/I forms to the Consortium. The College WC coordinator should submit all WC claims through the call center.**

RISK MANAGEMENT REVIEW STATEMENTS (Initial ONLY those statements that apply):	
<input type="checkbox"/>	THIS A/I IS FYI ONLY . NO CLAIM IS BEING SUBMITTED AT THIS TIME.
<input type="checkbox"/>	THIS A/I HAS BEEN SUBMITTED TO A-G ADMINISTRATORS, FOR CLAIM REVIEW (Student Accident Coverage).
<input type="checkbox"/>	THIS A/I HAS BEEN SUBMITTED TO SUMMIT AMERICA, FOR CLAIM REVIEW (Athletic Coverage).

_____ THIS A/I IS **FYI ONLY**. NO CLAIM IS BEING SUBMITTED AT THIS TIME.

_____ THIS A/I HAS BEEN SUBMITTED TO A-G ADMINISTRATORS, FOR CLAIM REVIEW (Student Accident Coverage).

_____ THIS A/I HAS BEEN SUBMITTED TO SUMMIT AMERICA, FOR CLAIM REVIEW (Athletic Coverage).

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DATE:

ACCIDENT – INCIDENT REPORT INSTRUCTIONS

This form is used to notify the Florida College System Risk Management Consortium (FCSRMC) of accidents/incidents/occurrences for review as possible claims. This form should be used to document the following types of occurrences: Accidents, Injuries, Crimes/Theft, Property Damage (College Owned), Property Damage (Non-College Owned), Internet Crisis (stolen, lost, or hacked personal information), Equipment Breakdown (fka Boiler and Machinery), Student Accidents, Athletic Injuries, and Allied Health (Professional Liability Claims). **Please note, Worker's Compensation claims are not reported to the FCSRMC using this form. The College's Worker's Compensation Coordinator should submit all claims via online submission at www.jeaim.com.**

1. LOCATION AND DATE OF INCIDENT/OCCURRENCE

COLLEGE: Clearly check the FCSRMC abbreviation for your college.

CAMPUS/LOCATION CODE: Please use the campus codes as noted on the College's Property Listings on file with the FCSRMC.

LOCATION OF OCCURRENCE (BE SPECIFIC): Provide campus name and building name or number. If accident occurred off campus, provide street address and city.

2. INJURED EMPLOYEE

OCCUPATION & DEPARTMENT: List the occupation and department in which the employee is primarily employed.

PART OF BODY INJURED: Loosely identify the part of the Employee's body which has been injured (i.e. wrist, ankle, back etc.)

TYPE OF INJURY: Loosely identify the manner in which the Employee has been injured (i.e. cut, sting, bruise etc.)

DATE INJURY FIRST REPORTED: If the injury was originally reported on a date different from the date of completing the A/I, please list the original date the injury was reported.

3. PROPERTY (COLLEGE OWNED)

IDENTIFY THE DAMAGED/LOST PROPERTY: Describe the damaged or stolen college-owned property. Enter information such as: "Flood damage to 1st floor of Building K; or 1998 white Mercedes driver side door; or Glass broken in classroom window; or IBM Pentium II computer, monitor, keyboard, and Hewlett-Packard LaserJet printer."

ESTIMATED COST OF DAMAGED/LOST PROPERTY: Enter your best guess of the value. This figure will not be used in evaluating the claim. It will be an indication of whether or not it falls within the college deductible and whether or not it needs to be submitted to the servicing office.

4. INJURED PARTY/PROPERTY (INJURY/LOSS TO PERSONS **NOT** EMPLOYEED BY COLLEGE AND/OR PROPERTY **NOT** OWNED BY COLLEGE)

NAME: Report the name of the impacted person, such as, students who are not employees of the college at the time of injury, visitors, or owners of property that is stolen or damaged while at the college, including art exhibits.

IDENTIFY THE INJURY OR THE DAMAGED/LOST PROPERTY: Enter information such as "Twisted knee; or 1989 white Mercedes convertible; or blue backpack with 4 textbooks; or Walkman radio/tape player; etc."

5. WITNESS(ES)

This information is extremely valuable in adjusting the claims or if suits are filed later. Please supply the information if it is available.

6. DESCRIBE THE LOSS/OCCURRENCE/INJURY (To be completed by the injured person, if at all possible):

Please do not write "SEE ATTACHED." Please give a brief description of accident using words such as: "College-owned vehicle was hit by vehicle owned by student; or Employee tripped over phone cord; or Student left backpack on library steps for 10 minutes; or Vehicle 1 (student-owned) hit vehicle 2 (student-owned) while backing out of parking space."

If additional space is required, feel free to **attach a second A/I form**.

It is extremely important to remember that those of us reading the accident/incident reports after they have left your college have no idea who the involved people are, whether they are college employees, students or visitors, and we have some difficulty determining whether or not damaged property is college owned or non-college owned.

7. SIGNATURES

Where possible, please get the signature of the Injured Employee/Party and a Department Contact.

8. RISK MANAGEMENT COORDINATOR REVIEW (To be completed by the College's Risk Management Coordinator):

Review by the Risk Management Coordinator or his/her designee are extremely important. Our belief is every incident should be submitted through the Coordinator's office for review and that office should accept responsibility for submitting the report to the Consortium office. It is important for loss control purposes to have one person at the college coordinating incident information and taking responsibility to make sure areas in need of repair are reported to the proper people for this to be accomplished.

GENERAL LIABILITY: Check this block when incident involves students, visitors, property of students or visitors.

COLLEGE PROPERTY: Check this block when incident involves property owned by the college.

EQUIPMENT BREAKDOWN: Check this block only when incident involves your college owned boiler and/or refrigeration equipment.

STUDENT ACCIDENT: Check this block if the injured party is enrolled in a covered curriculum.

ATHLETIC: Check if claimant was participating in an enrolled sport.

FACILITIES USE: Check this block when incident involves visitors to an event for which Facilities Use coverage has been purchased.

ALLIED HEALTH: Check this block when incident involves patients of students enrolled in the Allied Health Program. Be sure to attach an Allied Health Incident Form found at http://fcsrmc.com/attachments/Allied_Heath_Incident_Form.pdf

RISK MANAGEMENT REVIEW STATEMENTS: Initial the appropriate statements to let the FCSRMC staff know that the Risk Management Coordinator has reviewed the claim and determined that the A/I is for FYI purposes only, is a Student Accident claim that has been forwarded to Fringe Benefits, OR is an Athletic claim which has been submitted to Summit America. By initialing the appropriate statements, we hope to make the notification process more efficient and limit the number of follow-up calls the FCSRMC has to make to the College Risk Coordinator.