

## DIRECTIONS

This form must be filled out completely by the Staff person receiving the report with the injured/ill persons' input, if possible, including as many details as possible. If property damage loss, please include as much detail as possible.

Line 1: Fill in date (month/day/year) and day of week (Sunday – Saturday) and time of incident.

Line 2: Fill injured/ill person's full name.

Line 3: Indicate if they are a volunteer, visitor, client, resident or other.

Line 4: Fill in injured/ill person's full address, including zip code and phone # (with area code if out of state).

Line 5: Fill in injured/ill person's age, gender and occupation.

Line 6: Pertains to residents only

Line 7: State exact nature of incident. Be objective, including only facts, not opinions. (Examples: Resident slipped on wet floor and twisted left foot; complained of pain in right lower back. Resident fell on ice/glass broken by vandalism.)

Line 8: State exact location of incident. Address and exact location in building or on premises.

Line 9: Indicate and describe what type of treatment the ill/injured person received. First aid, bandaid, ice pack, etc; Hospital-admitted as a patient; Emergency Room treated and released; Outpatient-seen in doctor's office or clinic.

Line 10: Indicate name, address and phone of any physicians or hospitals used.

Line 11: Give name, address and phone of any witnesses ( including staff people ) to the incident.

Line 12: State whether there was snow or ice on the ground, it was raining, etc.

Line 13: State your thoughts as to whether there may be other responsible parties (Examples: service contractors and snow plow contractors).

Line 14: Injured/ill person should sign the form if possible. If report is taken by phone, please indicate this fact.

Line 15: Reporting Staff person must sign the form

Line 16: Fill in the date the report is completed.

**LIABILITY INCIDENT REPORT  
(Residents, Visitors, Volunteers, Clients, Property Damage)**

**Property Name:** \_\_\_\_\_

Important: This report should be filled out immediately by the staff member receiving information about an incident/accident.

1. Injury/illness/damage occurred: Date & Day of week \_\_\_\_\_ Time: \_\_\_\_\_
2. Name of injured/ill person: \_\_\_\_\_
3. Category of injured/ill person: Resident\_\_\_ Visitor\_\_\_ Volunteer\_\_\_ Client\_\_\_ Other\_\_\_\_\_
4. Address \_\_\_\_\_ Phone \_\_\_\_\_
5. Age\_\_\_ Sex\_\_\_\_\_ Occupation\_\_\_\_\_
6. Do you give permission to Avesta to share your D.O.B. and S.S.N. with insurance provider Y \_\_\_ N \_\_\_
7. State exact nature of incident. (Include (a) exact region of body affected (b) objects and (c) behaviors that may have caused incident (d) extent and cause of property damage)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Where did the incident occur? (Exact location)\_\_\_\_\_
9. Did the ill/injured receive medical treatment? What type? (First Aid, hospital, emergency room or outpatient?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Name, address and phone of physician or hospital (if applicable): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Name, address & phone of witnesses to the incident (if possible): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Describe weather conditions at the time of the incident \_\_\_\_\_
13. Are there any other parties that may be responsible for the illness/injury? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Signature of Injured/ill person: \_\_\_\_\_
15. Signature of reporting Staff: \_\_\_\_\_
16. Date report completed: \_\_\_\_\_