

Liability Report Form

Date: _____

Claimant's Name: _____ Age: _____ Phone: _____

Address: _____

Description of Occurrence: _____

Injuries: _____ Medical Care? YES NO

Ambulance? YES NO Hospital or Doctor: _____

Property Damage? YES NO describe same: _____

Is a Product Involved? YES NO Name and Size: _____

Name and Address of Manufacturer: _____

Did Claimant Slip, Fall, or Trip? _____ Was Area Inspected? YES NO

Foreign Matter or Debris Found on Floor? YES NO Describe:

Witnesses: Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Photos Taken? YES NO Additional Remarks: _____

Report Prepared By: _____