Risk Management Accident/Incident Report

(A copy of this report is not authorization for medical treatment.)

Instructions: All must complete sections 1 & 2.

Worker's Compensation claim, complete sections 3, 6, 7, and 8 below. (3A and 3B must be completed).
Student Accident/Incident, Visitor Accident/Incident or Volunteer Accident/Incident, complete sections 4, 6, 7, and 8 below.
Auto or Church Property Claim, complete sections 5, 6, 7, and 8 below (as appropriate).

Please Print: **Numerical Parish/School Code:**

1.	School/Parish Name			
	School/Parish/Agency	☐ Workers' Compensation ☐ Student Accident ☐ Prop Loss ☐ Auto ☐ Visitor Accident/Incident	Person Injured: ☐ Employee ☐ Visitor ☐ Student ☐ Volunteer	Claim Report Number:
2.	Accident			
	Date of Loss: MM/DD/YY ____/____/____	Time of Loss: _____a.m. _____p.m.	Location of Loss (Be specific)	
3.	Employee (Workers' Compensation Claims)			
	Name of Employee:		Date of Birth: ____/____/____	Type of injury (Cut, Bruise, Etc.)
	Occupation & Organization:		Part of Body Injured:	
	Home Address:	City: State:	Zip:	Phone No.:
	3A—Does Employee wish to seek medical attention today: ☐ Yes ☐ No A "No" answer above does not waive the employee's right to request medical attention at a later date.	If "Yes", Designate referral: (Name of Physicians, Clinic, Hospital)	3B—Will Employee require time off from work: ☐ Yes ☐ No	Expected return to work date: ____/____/____
4.	Claimant (Student, Accident/Incident, Visitor Accident/Incident or Volunteer Accident/Incident)			
	Name:		Date of Birth: ____/____/____	Time injury first reported:
	Address:	City: State:	ZIP:	Phone No.:
5.	Property (Church Owned) Attach picture of damaged or stolen property, Police and/or Public Safety report			
	Describe damaged or stolen property:			
	Estimated cost of damage or value of stolen item:			

6.	Witness(es)				
	Name:				
	Address:	City:	State:	Zip:	Phone No.:
	Name:				
	Address:	City:	State:	Zip:	Phone No.:

.	Describe Accident/Incident (To be completed by claimant. If claimant is unable to write, ask the following questions then write their response.)
A.	What were you doing when injury/loss occurred?
B.	How did the injury/loss occur?
C.	Object or substance that , in your opinion, directly injured or caused loss?
D.	Was training received and, if applicable, was personal protective equipment worn?
E.	What could have been done to avoid this mishap?
F.	State corrective action/lesson learned or recommendation.

8.	Signatures	
	Signature of Employee/Claimant:	Date:
	Signature of Entity Representative:	Date:

Send the ORIGINAL SIGNED DOCUMENT to Diocesan Insurance/Risk Management

Voluntary Statement

Name (Last, First, MI): _____

Address City, State, Zip: _____

Phone Number(s): _____

Date/Time: _____

Location where statement was made: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the facts contained herein are true and correct to the best of my knowledge.

X _____

Signature of the Person Making the Statement

Medical Treatment Authorization

Date:

To Whom It May Concern:

The Diocese of Pensacola-Tallahassee has chosen Gallagher Bassett Services, Inc. as their third party administration company to handle their Worker Compensaton claims. Any emergency medical care to stabilize the injuries to an injured worker will be authorized.

No additional prescription drugs are to be provided to the injured worker without pre-authorization from Gallagher Bassett Services, Inc. The Diocese of Pensacola-Tallahassee utilizes First Script's pharmacy network.

First Script Network Services Pharmacy Assistance: 1-866-445-7344

The Diocese of Pensacola-Tallahassee acknowledges the reimbursement rate for these services will be for treatment of workers' compensation injuries only, in accordance with the State of Florida Workers' Compensation Health Care Provider Reimbursement statute.

All services following initial treatment must be pre-approved by Gallagher Bassett Services, Inc. Copies of all reports should be sent to the carrier as listed below.

Employee Personal Information

Name: _____

Address: _____

_____

Phone: _____

Insurance Information

Date of Injury: _____

Employer at time of injury: **Diocese of Pensacola-Tallahassee**

Parish/School/Organization: _____

Phone: _____

_____

Signature of Injured Worker Date

Carrier/Administrator/ Authorization:
Gallagher Bassett Services, Inc.
P.O. Box 21227
Tampa, FL 33622
Phone: 866-428-0283

Billing Address for all providers:
Gallagher Bassett Services, Inc.
P.O. Box 2831
Clinton, IA 52733