INCIDENT/INJURY FORM

DATE: _____ EVENT: _____ MCC UNIT #: _____

DATE OF INCIDENT: _____ SPECIAL EVENTS INSURANCE COVERAGE: YES _____ NO _____

PARISH/INSTITUTION: _____ CALLER: _____

ADDRESS: _____ PHONE: _____

CITY: _____ PASTOR: _____

INJURED PERSON: _____ PHONE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

SOCIAL SECURITY NO.: _____-_____-_____ DATE OF BIRTH: _____ / _____ / _____

INJURED PERSON DATA (Age, sex, marital status, employment, etc.): _____

_____

_____

DESCRIPTION OF INCIDENT: _____

_____

INJURIES: _____

_____

MEDICAL TREATMENT (Where, when, etc.): _____

_____

_____

MEDICAL INSURANCE: _____

WITNESS INFORMATION:
NAME: _____ ADDRESS: _____ PHONE: _____

NAME: _____ ADDRESS: _____ PHONE: _____

DATA PERTINENT TO INCIDENT/INJURY: _____

_____

_____

_____

SIGNATURE OF INJURED PERSON: _____ DATE: _____

PLEASE REPORT ALL INJURIES IMMEDIATELY BY PHONE TO GALLAGHER BASSETT INSURANCE SERVICES:

2601 CAMBRIDGE COURT SUITE 435
AUBURN HILLS MI 48326
(248) 452-6050 FAX (248) 475-0228