



ST PETERSBURG COLLEGE
Florida Community College Risk Management Consortium
 5700 SW 34th Street · Suite 1205 · Gainesville, Florida 32608
ACCIDENT – INCIDENT REPORT

FOR FCCRMC USE ONLY

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LOCATION CODE

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1. COMMUNITY COLLEGE						
COLLEGE NAME: St Petersburg College	THIS REPORT: <input type="checkbox"/> W / C <input type="checkbox"/> CC Prop.	<input type="checkbox"/> Liability <input type="checkbox"/> Allied Health <input type="checkbox"/> Boiler & Mach.	PERSON INJURED: <input type="checkbox"/> Employee <input type="checkbox"/> Student	<input type="checkbox"/> Visitor <input type="checkbox"/> Volunteer	SOCIAL SECURITY NO:	
2. ACCIDENT:						
DATE OF LOSS:	TIME OF LOSS: <input type="checkbox"/> AM <input type="checkbox"/> PM	LOCATION OF LOSS (BE SPECIFIC):				
Instructions: If Worker's Compensation claim, complete sections 3,6, 7 and 8 below. 3A and 3B must be completed If General Liability or Allied Health claim, complete sections 4, 6, 7 and 8 below If College Property or Boiler & machinery, complete sections 5, 6, 7 and 8 below (as appropriate)						
3. CLAIMANT (WORKER'S COMPENSATION CLAIMS)						
NAME OF EMPLOYEE:	AGE:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
OCCUPATION & DEPARTMENT:		PART OF BODY INJURED:		TYPE OF INJURY (CUT, STING, BUMP, BRUISE, ETC):		
3A- DOES EMPLOYEE WISH TO SEEK MEDICAL ATTENTION TODAY: <input type="checkbox"/> YES <input type="checkbox"/> NO <small>A "NO" answer above does not waive the Employee's right to request medical Attention at a later date</small>		IF "YES" DESIGNATE REFERRAL (NAME PHYSICIAN, CLINIC, HOSPITAL):		3B – WILL EMPLOYEE REQUIRE TIME OFF FROM WORK: <input type="checkbox"/> YES <input type="checkbox"/> NO		RETURN TO WORK DATE
3C – DATE INJURY FIRST REPORTED			TIME INJURY FIRST REPORTED:			
4. CLAIMANT (GENERAL LIABILITY CLAIMS – Includes non-college employees and/or property not owned by college)						
NAME :	AGE:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
DESCRIBE INJURY OR DAMAGED PROPERTY:						
5. PROPERTY (COLLEGE OWNED):						
DESCRIBE DAMAGED OR STOLEN PROPERTY:						
					ESTIMATED COST OF DAMAGED OR VALUE OF STOLEN ITEM:	
6. WITNESS(ES)						
NAME:	AGE:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
NAME:	AGE:	ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
7. DESCRIBE ACCIDENT (To be completed by claimant if at all possible)						
8. SIGNATURE OF CLAIMANT:				DATE:		FOR WORKER'S COMPENSATION ONLY: DOES EMPLOYER AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
SIGNATURE OF SUPERVISOR:				DATE:		SIGNATURE RISK MANAGEMENT COORDINATOR: DATE: