

**Call this report in to:**  
 Sedgwick Claims Management Services  
 Phone: (866) 471-9518  
**Email a copy of report & pictures/video to:**  
 insurance@seattlearch.org

# Archdiocese of Seattle

## Confidential Incident or Accident Report

**Instructions on Use: Don't use for Workers' Compensation Claims involving injured employees which have their own forms.**

Whenever an situation occurs that results in damage or harm to people or property, or which could create a risk of potential liability, an employee of the Archdiocese of Seattle or any of its entities should strive to complete this form within 24 hours, report it to Sedgwick, and share the information with insurance.

This form is intended to be used as an internal, confidential record. Do not share or copy the information for any persons who are not our employees or authorized representatives (such as Chancery staff, our attorneys, or Sedgwick adjustors).

DATE OF REPORT	PARISH/SCHOOL/LOCATION NAME	LOCATION ID #	PICTURES TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY VIDEO OR CAMERA FOOTAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME OF INJURED (LAST, FIRST, M.I.)		AGE	GRADE (if applicable)	TELEPHONE NUMBER OF INJURED PERSON ( )
IS INJURED PERSON A MINOR? 1. <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF PARENT OR LEGAL GUARDIAN <i>(If Yes)</i> →		
ADDRESS OF PERSON INJURED (NUMBER, STREET, APT#, CITY, STATE, ZIP CODE) 2.				
WHERE DID THE ACCIDENT OCCUR? (Be specific, e.g. parish office front steps, south gym, student parking lot, etc...) 3.			DATE (MONTH, DAY, YEAR)	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
DESCRIBE HOW THE ACCIDENT OCCURRED (USE FACTS ONLY, NOT OPINIONS AND/OR GUESSES). IF NEEDED, ATTACH BLANK PAGES FOR EXTRA SPACE. 4.				
NAME (FIRST AND LAST) OF PERSON IN CHARGE AT TIME OF ACCIDENT 5.		TITLE	WERE THEY PRESENT AT THE TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO	DID INJURED PERSON BREAK ANY RULES? <input type="checkbox"/> YES <input type="checkbox"/> NO
6. NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NO.	TITLE/STATUS (Ex: Guest)	
NAME OF PARISH, SCHOOL, OFFICE, CEMETERY, ETC. 7.				
ADDRESS (NUMBER, STREET, CITY, ZIP CODE)			TELEPHONE NO. ( )	
8. APPARENT NATURE OF INJURY (PLEASE CHECK ALL THAT APPLY)		9. INJURED PART OF BODY (PLEASE CHECK ALL THAT APPLY)		
<input type="checkbox"/> Abrasion (Scrape) <input type="checkbox"/> Fracture <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Contusion (Bruising) <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal Injury or Pain <input type="checkbox"/> Concussion <input type="checkbox"/> Other (explain) _____		<input type="checkbox"/> Head <input type="checkbox"/> Finger <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Neck <input type="checkbox"/> Eye <input type="checkbox"/> Leg <input type="checkbox"/> Hand <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Face <input type="checkbox"/> Foot <input type="checkbox"/> Other (explain) _____		
WERE ANY FIRST AID PROCEDURES USED OR PROVIDED? 10.			NAME OF PERSON WHO ADMINISTERED FIRST AID	
WHERE DID THE INJURED INDIVIDUAL GO AFTER THE ACCIDENT OCCURED? 11. <input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital		WAS ANYONE NOTIFIED OF THE ACCIDENT? 12.		NOTIFIED PERSON'S RELATIONSHIP TO INJURED
IF THE INJURED PERSON LEFT OUR PREMISES, WHO TOOK THEM OR PICKED THEM UP? 13.			NAME OF ANYONE CONTACTING LOCATION FOR INFORMATION 14.	
15. MEDICAL BENEFITS AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OR COMPANY	ANY OTHER REMARKS 16.		
ANY OTHER REMARKS CONTINUED				

NAME OF PERSON COMPLETING REPORT 17.	TITLE	TELEPHONE NUMBER OF PERSON ( )
ADDRESS OF PERSON (NUMBER, STREET, CITY, STATE, ZIP CODE)		WAS PERSON AN EYE WITNESS <input type="checkbox"/> YES <input type="checkbox"/> NO
SIGNATURE OF PERSON APPROVING REPORT		DATE SIGNED

*Continue on reverse side or next page*

**SECONDARY REPORT FORMS FOR INCIDENT OR ACCIDENT**

*(ONLY COMPLETE THIS PAGE IF OUR EQUIPMENT, PROPERTY, OR MAINTENANCE MAY HAVE CAUSED OR CONTRIBUTED IN PART TO THE ACCIDENT. USE BLANK PAGES AS NEEDED FOR SPACE.)*

**EQUIPMENT REPORT: (TO BE COMPLETED IF EQUIPMENT WAS INVOLVED)**

Equipment involved (DESCRIBE): \_\_\_\_\_

Brand Name \_\_\_\_\_ Model or style number \_\_\_\_\_

Color \_\_\_\_\_ Size \_\_\_\_\_

Date Purchased \_\_\_\_\_ Where? \_\_\_\_\_

Manufacturer \_\_\_\_\_ Address \_\_\_\_\_

Condition of equipment: New \_\_\_\_\_ Used \_\_\_\_\_ Repaired \_\_\_\_\_

Approximate date of last service \_\_\_\_\_

Who has the equipment? (TRY TO KEEP ANY INVOLVED EQUIPMENT) \_\_\_\_\_

Describe nature of injury or damage \_\_\_\_\_

How did it occur? \_\_\_\_\_

Comments: \_\_\_\_\_

Name of person taking report \_\_\_\_\_

**INSPECTING EMPLOYEE'S REPORT: (TO BE COMPLETED IF PROPERTY WAS INVOLVED)**

Name (Print) \_\_\_\_\_

How soon after incident did you inspect location? \_\_\_\_\_ Location clean?  YES  NO

Dry?  YES  NO Any puddles?  YES  NO Describe lighting \_\_\_\_\_

Describe location or condition \_\_\_\_\_

Where were you when the incident occurred? \_\_\_\_\_

Did you see the incident?  YES  NO If so, describe fully \_\_\_\_\_

Injured person's comments and attitude (IF QUESTION IS NOT APPLICABLE, PUT N/A) \_\_\_\_\_

Signature \_\_\_\_\_

**MAINTENANCE OR CLEANING REPORT: (TO BE COMPLETED IF INJURED PERSON SLIPPED OR FELL)**

Name (Print) \_\_\_\_\_

Are you responsible for maintaining incident location?  YES  NO If not, who is? \_\_\_\_\_

Describe the normal schedule for cleaning the location: \_\_\_\_\_ Last time cleaned: \_\_\_\_\_

Any items replaced? \_\_\_\_\_ Floor product used? \_\_\_\_\_

When, before incident, did you last inspect location? \_\_\_\_\_

Describe its condition \_\_\_\_\_

Was location clean?  YES  NO Dry?  YES  NO Lighting working?  YES  NO

If elevator involved, specify exact one involved \_\_\_\_\_

Remarks: \_\_\_\_\_

**ARCHDIOCESE OF SEATTLE WITNESS STATEMENT***(Attach additional sheets if necessary)***LOCATION:***(Parish, School, Entity)***1. WITNESS INFORMATION**

a. NAME OF WITNESS:

b. TITLE OR STATUS OF WITNESS *(Ex: School Principal, Parishioner, Visitor, Client)*c. HOME ADDRESS *(Include ZIP Code)*

d. E-MAIL ADDRESS

e. WORK TELEPHONE NUMBER

f. CELLULAR TELEPHONE NUMBER

g. HOME TELEPHONE NUMBER

**2. ACCIDENT INFORMATION**

a. DID YOU WITNESS THE ACCIDENT?

b. DATE OF ACCIDENT:

c. TIME OF ACCIDENT:  *a.m.*d. TIME YOU ARRIVED AT SCENE?  *a.m.* *p.m.* *p.m.*3. WHERE DID THE ACCIDENT OCCUR? *(Give General Description and Street Location, City, and State if known)*

4. TELL IN YOUR OWN WAY HOW THE ACCIDENT HAPPENED.

5. WAS ANYONE INJURED, AND IF SO, EXTENT OF INJURY IF KNOWN?

6. DESCRIBE THE APPARENT DAMAGE TO PRIVATE PROPERTY.

7. DESCRIBE THE APPARENT DAMAGE TO ARCHDIOCESE PROPERTY.

8. DESCRIBE ANY CONDITIONS THAT MAY HAVE INFLUENCED THE ACCIDENT *(e.g. weather, terrain, debris, construction work, time of day).*

9. DID YOU NOTICE ANYTHING UNUSUAL PRIOR TO OR DURING THE ACCIDENT?

*IF YES, PLEASE DESCRIBE WHAT YOU NOTICED AND WHY YOU THINK IT WAS PERTINENT TO THIS ACCIDENT.*

WITNESS SIGNATURE:

I ACKNOWLEDGE THESE STATEMENTS ARE BASED ON PERSONAL OBSERVATION OF THE EVENTS AND THAT IT IS TO THE BEST OF MY KNOWLEDGE, A TRUE AND ACCURATE STATEMENT OF FACT.

DATE: