Vernon Township Accident/Incident Report

Return to: Pinnacle Risk Solutions
Email: jmaffucci@pinnrisk.com - Fax: 973-284-1655

	AUTO	LIABILITY	PROPERTY	EPLI	INLAND/OCEAN MARINE	THEFT	Workers' Comp	Other
CLAIM TYPE:								

Date of Loss: _____ **Loss Location:** _____

Time: _____ AM: ◯ _____

PM: ◯ _____

Point of Contact: _____ **Contact's Job Title:** _____

Phone:

Work: _____ **Cell:** _____

Fax: _____ **e-mail:** _____

Loss Description: _____

Emergency Services:	Police	Fire	EMS	Other

Report #: _____

Department Name(s): _____

Claimant Information:

(1) Name: _____ **(2) Name:** _____

Address: _____ **Address:** _____

Phone

Home: _____

Cell: _____

Work: _____

Phone

Home: _____

Cell: _____

Work: _____

Employees Involved:

(1) Name: _____ **(2) Name:** _____

Address: _____ **Address:** _____

Phone

Home: _____

Cell: _____

Work: _____

Phone

Home: _____

Cell: _____

Work: _____

Report Prepared By: _____ **Date:** _____ **Phone #:** _____

Signature: _____ **Date:** _____

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Insured Equipment: _____ **VIN:** _____

Operator's Name: _____

Damage to Equipment: _____ **Driver License #:** _____

_____ **State:** _____

Claimant Information:

(1) Name: _____ **(2) Name:** _____

Address: _____ **Address:** _____

_____ _____

_____ _____

Phone: _____ **Phone:** _____

(3) Name: _____ **(4) Name:** _____

Address: _____ **Address:** _____

_____ _____

_____ _____

Phone: _____ **Phone:** _____

Clamaint's Vehicle Info

Vehicle 1

Year: _____ **Make:** _____ **Model:** _____

VIN: _____ **Ins. Co:** _____

Policy #: _____

Vehicle 2

Year: _____ **Make:** _____ **Model:** _____

VIN: _____ **Ins. Co:** _____

Policy #: _____

Witnesses:

(1) _____ **(2)** _____

Address: _____ **Address:** _____

_____ _____

Phone #: _____ **Phone #:** _____

Remarks: _____

_____

_____

Report Prepared By: _____ **Date:** _____ **Phone #:** _____

Signature: _____ **Date:** _____

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THIS PAGE FOR COMPENSATION CLAIMS ONLY

Date of Hire: _____ **AWW:** _____ **Paid While Out:** ◯ Yes ◯ No

State of Hire: _____ **RTW Date:** _____ **Pay Continuing:** ◯ Yes ◯ No

Job Title: _____

Last Day Paid: _____

Department: _____

DOB: _____ **Last Day Worked:** _____

SSN: _____ **First Day of Disability:** _____

Work Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start Time:							
Stop Time:							

Supervisor: _____ **Phone:** _____

Affected Body Part(s): _____

_____

_____

Medical Provider: _____

Address: _____

_____

_____

_____

Phone: _____

Fax: _____

e-mail: _____

HAS THE EMPLOYEE HAD PRIOR WORKERS' COMPENSATION CLAIMS WITH YOU?

Date: _____ **Body Part:** _____

Date: _____ **Body Part:** _____

Date: _____ **Body Part:** _____

Date: _____ **Body Part:** _____

Report Prepared By: _____ **Date:** _____ **Phone #:** _____

Signature: _____ **Date:** _____

Dept. Head's Name: _____

Signature: _____ **Date:** _____

Business Admin Name: _____

Signature: _____ **Date:** _____