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ACCIDENT/INCIDENT REPORT FORM (OTHER THAN AUTO)

Claims Facilitator: _____

Company Name: _____

Address: _____

Employee Completing Report/Title: _____ Phone: _____

Supervisor: _____ Phone: _____ Date: _____

TYPE OF INCIDENT

- Injury to Person (non-employee)
- Damage to Company Property
- Damage to Other's Property

DATE OF INCIDENT: _____

Time: _____ Weather Conditions: _____

Location of Accident/Incident: _____

Photos Attached? Yes No Will follow-up

Manager on duty: _____ Phone: _____

Employee first notified: _____ Phone: _____

Police/Fire/Ambulance Department name: _____

What Happened? _____

Name of person that alerted you of the incident: _____ Phone: _____

INJURY to Person (non-employee):

Name of Injured Person: _____ Address: _____

Phone: _____

Approximate Age of Injured Person: _____

Any observable Previous Health Issues? Yes No If so, describe: _____

Was Medical Attention sought: Yes No When: _____

What is the Injury? _____

PROPERTY DAMAGE:

What was damaged? _____ Owner: _____ Phone: _____

Estimated Cost of Damage: \$ _____

WITNESSES - Names & Phone Numbers:

Name: _____ Phone: _____ Name: _____ Phone: _____