ICRMP
Member Owned. Member Driven

Member Incident/Potential Claim Form

For Notification Use Only.
To Be Completed by Risk Manager and Sent to ICRMP
when Tort/Claim HAS NOT been Filed by Claimant.

MEMBER NAME:_____
(PLEASE PRINT)

1. Mailing Address:

_____

2. City/State/Zip:

_____

3. Risk Manager/Contact:

_____

4. Phone: _____ **Email:**_____

5. Fax:_____

6. Date of Incident: _____ **Department Involved:**_____

7. Who reported the incident to you?_____

8. Time of Incident: _____ **a.m./p.m.** **(circle one)**

9. DESCRIBE IN DETAIL WHAT DAMAGE OR INJURY OCCURRED: **(Attach additional documentation if necessary)**

_____

_____

_____

Employee(s) / Persons Involved:_____

If this incident could have been avoided describe how:

_____

_____

_____

Signature: _____ **Date:**_____