

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:** _____