GC INSURANCE
Services
ABN 19 245 449 177

ASR underwriting AGENCIES

# Public Liability Incident Report

| | | | | | |
|---|---|---|---|---|---|
| **Insured** | | | | | |
| **Policy Number** | | | | | |
| **Date Reported** | / / | **Time Reported** | : am pm | | |
| **Exact Location** | | | | | |
| **Date of Incident** | / / | **Time of Incident** | : am pm | **Day of Week** | |
| **Incident Report Completed by** | | | | | |
| **Incident Reported to** | | | | | |
| **Time Incident Location Inspected** | : am pm | **Inspected By** | | | |

## PART 1: Injured Persons Details

Full Name

Address

Home Phone | Business Phone | Mobile Phone

Date of Birth / / (Approx age if DOB unknown) ☐ Male ☐ Female

## PART 2: Witness* Details

* Eyewitnesses who witnessed the incident; circumstantial witnesses who witnessed the events leading up to or following the incident. Provide additional witness details on attachment.

Full Name

Address

Home Phone | Business Phone | Mobile Phone

Witness Type ☐ Eye Witness ☐ Circumstantial Witness

Relationship to Injured Person

If more than one Witness Please provide details

If any Other Party responsible Please provide details

## PART 3: Personal Injury Details

**Part of the body injured**

☐ Head & Neck ☐ Back & Trunk ☐ Shoulder ☐ Hands / Fingers ☐ Feet & Toes
☐ Eyes or Face ☐ Hip ☐ Arms / Wrists ☐ Knee

If Other or Multiple please describe

**Nature of Injury**

☐ Multiple ☐ Dislocation ☐ Major Bruising (Disabling) ☐ Minor Concussion
☐ Fracture ☐ Ligament Damage ☐ Minor Cur/Laceration (no stitches) ☐ Concussion/Unconscious (serious)
☐ Sprain ☐ Minor Bruise (not disabling) ☐ Cut/Laceration (requiring stiches) ☐ Superficial
☐ No Apparent Injury

If Other please describe

## PART 3: Personal Injury Details

Description of and sequence of events leading up to the Incident (as described by injured party)

Description of Incident (by you or independant witness including an un-biased view on whether the injured person contributed to the injury)

Was injured Person taken to: ☐ Treatment by First Aider ☐ Doctor/Hospital ☐ Ambulance ☐ _____

Name of First Aider attending | Contact Phone

**If Third Party/Contractor at fault:**

Third Party/Contractor Name

Third Party/Contractor Insurance Details

## PART 4: Property Damage (Complete if there is property damage)

Item Damaged

Details

If viewed and by whom

Photos taken and by whom

**SIGNATURE** X | Dated / /

**NAME** | Position