



**STATE OF MINNESOTA
GENERAL LIABILITY INCIDENT REPORT**
(To be completed by appropriate agency employees
for cases **not involving an automobile**)

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|-------------------|-------|-------------------------|--------------------|
| Name of Agency: | | Name of contact Person: | |
| | | Phone Number: | |
| Date of Accident: | Time: | am/pm | Weather Conditions |

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| Description of Incident (How, where, and why): |
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| Extent of Damage to Property |
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| Extent of Injury to Person(s) |
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|---|
| Person(s) Injured (Names, addresses and telephone number's) |
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| Witnesses (Names, addresses, and telephone numbers): |
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|--|---|
| Submit Claim to: Claims Department Risk Management Division 320 Centennial Office Building 658 Cedar Street St. Paul, MN 55155-1401 | Name, Address, Phone of person completing form: |
| Emergency Reporting – After hours and weekends: Allied Adjusters: (612) 766-3700 or (800) 709-9509 | Additional Comments: |