NONEMPLOYEE ACCIDENT INJURY REPORT

Minnesota Counties Intergovernmental Trust
100 Empire Dr., Suite100, St. Paul MN 55103
Toll-free: 1.866.547.6516 Local: 651.209.6400

SUBMIT REPORT to Central Services

Member Name			
Claimant Name		**Claimant Age**	
Claimant Address		**Marital Status**	
Claimant E-mail		**Claimant Primary Phone**	
Claimant Occupation		**Claimant Alternate Phone**	
STATEMENT			
Date		**Time (include a.m./p.m.**	

Address of Incident			
Location of Incident (choose one)	☐ Indoors	☐ Outdoors	☐ Other:
How did the incident occur?			
How was the incident reported?			
What injuries resulted?			
What medical care is to be/was rendered?			
What is the name of the treating physician/hospital?			
Who was with the claimant at the time of the incident?			
What caused the incident (activities, equipment, person, conditions involved)?			

Employee receiving the above statement			
Date		**Claimant's Signature**	
SUPERVISOR/EMPLOYEE STATEMENT			
Employees who saw the incident			
Employee's description of the incident			
Condition of the area			
Comments (employees' opinions):			

WITNESS INFORMATION			
Name	**Address**	**Phone**	**E-mail**