STATE OF MINNESOTA
GENERAL LIABILITY INCIDENT REPORT

(To be completed by appropriate state employees and persons involved in or observing an accident **not involving an automobile**)

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

Description of Incident (How where, and why):

Extent of Damage to Property

Extent of Injury to Person(s)

Person(s) Injured (Names, addresses and telephone number's)

Witnesses (Names, addresses, and telephone numbers):

Submit Claim to: Claims Department Risk Management Division 309 Administration Building 50 Sherburne Avenue St. Paul, MN 55155-1401	Name, Address, Phone of person completing form:
Emergency Reporting to GAB: (After hours and weekends) Phone: 1-800-464-2034	Date of Report and Signature: