HSC001, 3-27-15 J Sandvick

La Crosse Medical Health Science Consortium
Claimant Incident Report

Claimant Name	Work Phone		Home Phone
Home Address			Date of Accident
City	State	Zip + 4	Hour AM PM
Full Description of the accident including specific location and activity involved in at the time of the incident. (Use the back of this sheet if additional space is needed.)			

Injuries	Describe full extent of injuries, no matter how minor.		
Witnesses	Name	Full Mailing Address	Phone No. Including Area Code
Property Damage	Type of Property	Type of Damage	
	If different than home address, address where damaged property may be seen		Estimated Repair Cost

I certify that the information in this report is a complete and accurate description of the incident.	Claimant Signature	Date

Return Completed Report To:

UW-La Crosse
Attn: Risk Manager
1725 State Street
La Crosse, WI 54601

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Copy of Completed Report To: LMHSC - HSC 3065