

**La Crosse Medical Health Science Consortium (LMHSC)
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
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: LMHSC – HSC Room 3065

LMHSC will provide copy to respective HSC partner, if appropriate.