



LIABILITY INCIDENT REPORT

FOR STATE AGENCY USE ONLY

Agency Name:	University of Mary Washington				
Date Reported:		Time:		Agency Code:	215

CLAIMANT DATA

Name					
Address					
Phone					

LOSS DATA

Date:		Time:			
Location:					
Estimate of loss:					
Description of incident:					

FOR INFORMATION, CONTACT

Name:		Title:			
Address:					
Local Phone Number:		Email:			

REPORTED BY

Name:		Title:			
Address:					
Local Phone Number:		Email:			

COMMENTS
