FOR DRM EYES ONLY

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:		FAX:	

REPORTED BY

Name:		Title:	
Address:			
Local Phone Number:		FAX:	

COMMENTS