

For University Office Use Only

CLAIM NUMBER:	CLAIM TOTAL:
Campus Review: <input type="checkbox"/> Approved <input type="checkbox"/> Denied	University Review: <input type="checkbox"/> Approved <input type="checkbox"/> Denied
Trust Check #:	Release Form: <input type="checkbox"/> Received <input type="checkbox"/> Not Applicable
Claim Closed	
_____ Signature _____ Date	Notes:

*To file a claim, the following information must be completed in its entirety, including itemized receipts of out-of-pocket expenses, contact information of any witnesses, and pictures related to the incident. **The completion of this form does not guarantee approval of the claim and reimbursement of related expenses.** Upon review, you will be contacted by the University with additional information.*

Claimant Name: _____

Address: _____

Phone: _____ **Email:** _____

Campus Status: Student Employee Visitor Department

Date of Incident: _____ **Time of Incident:** _____

Type of Loss: Property Equipment Vehicle Personal Injury
 Other _____

Describe the incident:

Where did the incident occur?

Did this occur at a University-sponsored event? No Yes

If Yes, list event: _____

What caused the incident and any related injuries or damage?

Did you receive treatment for the injury or repair any damages? If so, where?

Who was notified and/or responded to the incident?

- Campus Police Campus Risk Management Student Health EMTs
 Fire Department HAZMAT Team Kearney Police
 Other _____

Who was the incident initially reported to and when?

Name: _____ Phone: _____

Date: _____

Please list all witnesses:

<u>Name</u>	<u>Email</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Were any photos taken of the incident? No Yes (Attach all photos to this form)

Estimated Total Amount of Loss: \$ _____

**Claimant's personal insurance would be the primary coverage for all incidents. Itemized receipts of out-of-pocket expenses directly related to the incident must be submitted with this report for full review and consideration.*

I, the Claimant, hereby certify that the information and statements provided on this form are true and correct to the best of my knowledge.

Claimant Signature

Date