UNIVERSITY OF MARYLAND BALTIMORE

ADVERSE INCIDENT REPORT

INSTRUCTIONS

- This form is only to be used for potential liability claims against UMB and/or to document an adverse incident on behalf of a patient, student, volunteer, research participant, etc.
- This form is **not** to be used for work-related injuries involving employees or departmental appointed volunteers.
- The form can be completed by the injured party (claimant) or the departmental representative who was notified of the incident.
- The form can be submitted to The Office of Risk Management, by facsimile 410-706-0954 or electronic mail UMBRiskManagement@umaryland.edu. Keep a copy for your records.
- Please note that this is **not** a formal notice of claim against UMB on behalf of the injured party, it is simply a notification and serves as documentation of an adverse incident. If the injured party wishes to file a notice of claim against UMB, please contact the Office of Risk Management at 410-706-4781 for further instructions.

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ADVERSE INCIDENT REPORT

CLAIMANT INFORMATION

FULL NAME:

ADDRESS:

CITY: **STATE:** **ZIP:**

HOME PHONE: **WORK PHONE:**

UMB AFFILIATION (identify as student, volunteer, or none) :

TIME AND PLACE

LOCATION OF INCIDENT/BUILDING:

LOCATION ADDRESS:

LOCATION CITY: **STATE:** **ZIP:**

DATE OF INCIDENT: **TIME OF INCIDENT:** **AM/PM** Choose one:

POLICE NOTIFIED: Choose one: **POLICE REPORT NO.:**

MEDICAL TREATMENT

HOSPITAL CARE: Choose one: **NAME OF HOSPITAL:**

NOTIFICATION

NAME OF PERSON NOTIFIED:

CONTACT NUMBER: **TIME OF NOTIFICATION:** **AM/PM** Choose one:

INCIDENT DESCRIPTION:

PRINTED NAME: _____ **DEPT.:_____**

SIGNATURE_____ **DATE_____**