

Mission One

Educational Staffing Services

First Report of Accident / Incident

Date of Injury/Incident: ____/____/____ Time of Injury/Incident: _____

Date of this Report: ____/____/____

1. Carrier/Group Name: Guarantee Insurance Company
2601 Cattlemen Road, Suite 402
Sarasota, FL 34232
www.guaranteeins.com

2. Policy Number: GWIC301000475-109

Injured Person's Name: _____

Date of Birth: ____/____/____

Injured Person's Contact Details:

Address: _____

Telephone no: _____

Social Security #: _____

Where did the incident occur? _____

Description of Injury: _____

Is Medical Treatment Required, if
yes please describe?

If medical treatment is not
requested injured person must
sign here: _____

Were there witnesses to the
incident?
(yes/no)

(If yes, please provide details)

Name: _____

Address: _____

Telephone no: _____

Report completed by: _____

(Please print name and title)

Fax completed form to (856)334-1713. Please call Tara Merriman (856) 630-0175 in an emergency.