FLORIDA COLLEGE SYSTEM RISK MANAGEMENT CONSORTIUM

ALLIED HEALTH INCIDENT

College Name: _____

Incident Date: _____

Claimant: _____

Student Involved: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( ) _____

Program of study in which student is enrolled: _____

College **Faculty Supervisor** Name: _____

Faculty Supervisor Work Phone: ( ) _____

College **Coordinator of Program** Name: _____

Coordinator of Program Work Phone: ( ) _____

Hospital or facility where incident allegedly occurred: _____

_____

_____

Send Completed Form To:

Florida College System
Risk Management Consortium
4500 NW 27 Street
Suite D2
Gainesville, FL 32606
Fax: 352-955-2069