# [League of Minnesota Cities](https://www.lmc.org/)

# Report of Injury to City Volunteer

### **Do not use a workers’ compensation first report of injury form to report injuries to volunteers. Use this form only. For injuries to employees, use a** [**first report of injury form**](https://www.dli.mn.gov/sites/default/files/pdf/fr01.pdf)**.**

### *Please note:*

### Report by telephone all cases involving bodily injury necessitating hospitalization.

1. Do not discuss claim with anyone except a representative of the League of Minnesota Cities Insurance Trust (LMCIT).
2. Submit all documentation to LMCIT as soon as possible.
3. This form must be signed by an authorized representative of the city.

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| **Return completed form to:**League of Minnesota Cities Insurance Trust145 University Ave WSt Paul MN 55123 | Phone: (651) 281-1200 or (800) 925-1122Fax: (651) 281-1297 or (888) 234-7839Email: claims@lmc.org |

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| Section 1: City Information |

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| Name | Click or tap here to enter text. |
| Address (Street, City, State, Zip) | Click or tap here to enter text. |
| Phone number | Click or tap here to enter text. |
| Coverage agreement number | Click or tap here to enter text. |

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| Section 2: Time & Place |

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| Date of accident | Click or tap here to enter text. |
| Time | Click or tap here to enter text. |
| Location of accident | Click or tap here to enter text. |

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| Section 3: Description of Accident | |
| 1. Full description and cause of accident | Click or tap here to enter text. |
| 1. What kind of work or activity was volunteer doing? | Click or tap here to enter text. |
| 1. On what dates was work activity done? | Click or tap here to enter text. |
| 1. Was accident caused by a city employee? If yes, provide employee’s name. | Click or tap here to enter text. |
| 1. Was accident caused by another person? If yes, provide person’s name, their employer’s name and employer’s address (Street, City, State, Zip). | Click or tap here to enter text. |
| 1. Who owns the premises where accident occurred? | Click or tap here to enter text. |

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| 1. Do any leases or contracts control your use of these premises? | Click or tap here to enter text. |

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| Section 4: Witnesses |

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| 1. Names | Click or tap here to enter text. |
| 1. Addresses (Street, City, State, Zip) | Click or tap here to enter text. |

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| Section 5: Injured Volunteer & Injuries |

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| 1. Name of injured volunteer | Click or tap here to enter text. |
| 1. Address (Street, City, State, Zip) | Click or tap here to enter text. |
| 1. Phone number | Click or tap here to enter text. |
| 1. Age | Click or tap here to enter text. |
| 1. Social security number | Click or tap here to enter text. |
| 1. Married or single? | Click or tap here to enter text. |
| 1. Nature and extent of injuries | Click or tap here to enter text. |
| 1. Name of doctor or hospital and address (Street, City, State, Zip) | Click or tap here to enter text. |
| 1. By whom is injured volunteer employed? | Click or tap here to enter text. |
| 1. Did injured volunteer lose time from work because of this injury? | Click or tap here to enter text. |
| 1. Has injured volunteer returned to work? | Click or tap here to enter text. |

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| Section 6: Additional Information / Comments |

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| Click or tap here to enter text. |

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| Section 7: Submission |

Signature of authorized representative:

Printed name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Date: Click or tap here to enter text.