



Member Notice of Potential Claim

**For Notification Use Only.
To Be Completed By Risk Manager and Sent to ICRMP
when Tort HAS NOT been Filed By Claimant.**

Member Name: _____

Mailing Address: _____

City: _____ **Zip Code:** _____

Risk Manager: _____ **E-mail:** _____

Phone Number: _____ **Fax:** _____

Date of Incident: _____

Who reported the claim to you: _____

Department Involved: _____

Employee(s) Involved: _____

Provide a Description of What Happened:
(Please attach any additional information you deem necessary)

Risk Manager Signature: _____ **Date Signed:** _____