



# MISSISSIPPI FORESTRY COMMISSION

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## Completing the Liability Claim Reporting Form

**Agency:** Provide the name of your agency.

**Department/District:** Provide a more specific location within your agency, such as Boswell Regional Center or Roosevelt State Park.

**Address:** Indicate the address or physical location where the incident occurred. If the incident occurred away from the agency, indicate the regular agency address or address for the person that Management Services USA, Inc. and the Tort Claims Board will be contacting at the agency.

**Person to Contact/Telephone Number:** Indicate the name of the person who Management Services USA, Inc. and the Tort Claims Board can contact to obtain any additional information concerning this claim, and their telephone number.

**Question #1.** This section will include the date and time of the loss, as well as a description of the accident. Please confine this description to the details of the loss as opposed to speculative remarks.

**Question #2.** Complete this section if the accident involved a state vehicle. Include the name of the state driver, home address and telephone number, and description of the vehicle including make, year model, license tag number, and agency equipment identification number.

**Question #3.** Describe the property damage to it. Indicate the property owner's name, address, telephone number, and a physical address where the damage property may be viewed.

**Question #4.** Indicate the name, address, and telephone number for any person injured as a result of this incident who might conceivably file a claim against the agency or state. Even if the person indicated he/she was not injured, but went to the doctor's office or emergency room for a checkup, you should include his/her name, address, and telephone numbers. Describe the injuries received by the claimant, if the claimant was taken to the hospital, and the name of the hospital.

**Question #5.** Use this section to include the names, addresses and telephone numbers for any additional claimants.

**Question #6.** Indicate the name, address, and telephone numbers for any witnesses and/or passengers.

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**Note:** *This form should not be confused with the notice of claim requirements found in Section 11-46-11 of the Tort Claims Acts. This form is to be used by state agencies to notify the Tort Claims Board and Management Services USA, Inc. of an occurrence. It should not be given to a claimant for use of filing a claim.*



STATE OF MISSISSIPPI  
LIABILITY CLAIM REPORTING FORM

Agency: Department/District:  
Address: City/State/Zip:  
Person to Contact: Telephone Number:

**1. If accident, other than automobile, please complete this section:**

Name: Social Security No.:  
Home Address: City/State/Zip:  
Home Telephone Number: Work Telephone Number:  
Date of Loss: Time of Loss: Location of Accident:  
Description of Accident:

**2. If automobile accident, please complete the following: (State Employee and State Vehicle):**

Name of State Driver: Social Security No.:  
Home Address: City/State/Zip:  
Home Telephone Number: Work Telephone Number:  
Date Of Loss: Time of Loss: Tag No.:  
Description of State Vehicle Involved:  
Description of Accident:

**3. If property, other than State owned, was damaged, please complete the following:**

Described Property: Described Damage:  
Owner's Name: Telephone Number:  
Home Address: City/State/Zip:  
Where can property be seen?

**4. If injuries involved, please complete the following: (Other than State Employee)**

\*\* All injured State employees should be reported to Worker's Compensation.  
Injured Party's Name:  
Home Address: City/State/Zip:  
Home Telephone Number: Work Telephone Number:  
Describe Injury:  
Was injured person taken to doctor/hospital? Yes No  
If yes, where was the injured person taken?

**5. If more than one person was injured, please list name and address of all other injured parties: (Other than State Employee)**

**A.** Injured Party's Name:  
Home Address: City/State/Zip:  
Home Telephone Number: Work Telephone Number:  
**B.** Injured Party's Name:  
Home Address: City/State/Zip:  
Home Telephone Number: Work Telephone Number:

**6. Witness/Passengers:**

Witness Name:  
Home Address: City/State/Zip:  
Home Telephone Number: Work Telephone Number:

**7.**  
Person completing this form: Date Form Completed