

## INCIDENT/ACCIDENT REPORT FORM

THIS FORM DOES **NOT** COMPLY WITH RCW 4.96.020 FOR THE FILING OF A CLAIM FOR DAMAGES

**FORM INSTRUCTIONS** This form to be completed **by DISTRICT PERSONNEL ONLY**. Do not allow student or parents/injured party to complete. Do not use this form to report employee (on the job) injuries. Complete and forward this form to the Pool at earliest opportunity. Send supplemental information under separate cover if necessary. Remember to report all District property theft and vandalism claims to law enforcement also.

<b>DISTRICT:</b>		<b>SCHOOL NAME:</b>		<b>COMPLETED BY:</b>	
CONTACT			PHONE NUMBER		
DATE OF INCIDENT/ACCIDENT		TIME	AM	PM	<input type="checkbox"/> INJURY <input type="checkbox"/> VEHICLE <input type="checkbox"/> NON-VEHICLE PROPERTY DAMAGE/LOSS
LOCATION	<input type="checkbox"/> CLASS	<input type="checkbox"/> PLAYGROUND	<input type="checkbox"/> GYM	<input type="checkbox"/> LABORATORY	<input type="checkbox"/> SHOP <input type="checkbox"/> OFF-PREMISES <input type="checkbox"/> OTHER, SPECIFY
DESCRIPTION OF INCIDENT/ACCIDENT/DAMAGE					
WITNESS(ES)					PH #
IDENTIFY AGENCY CALLED TO SCENE ( <i>police, fire, etc.</i> )					REPORT #
<b>INJURIES</b> ( <i>complete separate form for each injured individual</i> )					
NAME			STUDENT/EMPLOYEE/OTHER		
LAST	FIRST	MIDDLE	GENDER	AGE	GRADE
ADDRESS					
STREET		CITY	ZIP CODE		
NAME OF PARENT/GUARDIAN ( <i>if applicable</i> )					HOME PH
ADDRESS OF PARENT					WORK PH
PART OF BODY INJURED			TYPE OF INJURY ( <i>e.g., cut, burn</i> )		CELL PH
EXTENT OF INJURY ( <i>e.g., minor, severe</i> )				NO. OF SCHOOL DAYS LOST	
NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT				TITLE	PHONE #
ACTION TAKEN / BY WHOM / WHEN				PRESENT AT SCENE?	YES   NO
<input type="checkbox"/> SENT TO HEALTH ROOM <input type="checkbox"/> SENT HOME <input type="checkbox"/> 911 CALLED <input type="checkbox"/> SENT TO HOSPITAL / DOCTOR				IF STUDENT, ACCIDENT INS.	YES   NO
<b>NON-VEHICLE PROPERTY DAMAGE / LOSS</b>					
PROPERTY DESCRIPTION / DAMAGE					
OWNER					EST. LOSS \$
ADDRESS				PHONE	DIST. EMPLOYEE   YES   NO
<b>DAMAGE TO DISTRICT VEHICLE / OR OTHER VEHICLE</b> ( <i>attach state accident report if available</i> )					WORK
<b>DISTRICT VEHICLE</b> <input type="checkbox"/> BUS <input type="checkbox"/> CAR/TRUCK/VAN <input type="checkbox"/> OTHER   YR _____ MAKE _____ MODEL _____					
			LIC #	VIN #	
DRIVER NAME		HOME PHONE		WORK PHONE	
DESCRIBE DAMAGE					EST. LOSS \$
CITATION / VIOLATION		DISTRICT DRIVER		OTHER DRIVER	
<b>OTHER VEHICLE</b> YR		MAKE	MODEL	LIC #	VIN #
DRIVER NAME / ADDRESS					PHONE
OWNER NAME / ADDRESS					PHONE
DESCRIBE DAMAGE					
OTHER VEHICLE INSURANCE CO.					POLICY #
INSURANCE AGENT / ADDRESS					PHONE #

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