

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.

INFORMATION:		DISTRICT	SCHOOL NAME:	COMPLETED BY:			
CONTACT		PHONE NUMBER					
DATE OF INCIDENT/ACCIDENT	TIME	AM / PM	<input type="checkbox"/> INJURY	<input type="checkbox"/> VEHICLE	<input type="checkbox"/> PROPERTY DAMAGE/LOSS (<i>non-vehicle</i>)		
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 #	
INJURIES (<i>complete separate form for each injured individual</i>)							
NAME				STUDENT/EMPLOYEE/OTHER			
LAST		FIRST	MIDDLE	GENDER		AGE	GRADE
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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> SENT TO SCHOOL NURSE				<input type="checkbox"/> SENT HOME		<input type="checkbox"/> 911 CALLED	
<input type="checkbox"/> SENT TO HOSPITAL / DOCTOR				IF STUDENT, ACCIDENT INS. <input type="checkbox"/> YES <input type="checkbox"/> NO			
NON-VEHICLE PROPERTY DAMAGE / LOSS							
PROPERTY DESCRIPTION / DAMAGE						SER #	
OWNER						EST. LOSS \$	
ADDRESS				PHONE		DIST. EMPLOYEE <input type="checkbox"/> YES <input type="checkbox"/> NO	
DAMAGE TO DISTRICT VEHICLE / OR OTHER VEHICLE (<i>attach state accident report if available</i>)						WORK	
DISTRICT VEHICLE		<input type="checkbox"/> TO/FROM SCHOOL		<input type="checkbox"/> PARKING LOT		<input type="checkbox"/> OTHER	
YR _____		MAKE _____		MODEL _____			
LIC # _____				VIN # _____			
DRIVER NAME			HOME PHONE		WORK PHONE		
DESCRIBE DAMAGE						EST. LOSS \$	
CITATION / VIOLATION		<input type="checkbox"/> DISTRICT DRIVER		<input type="checkbox"/> OTHER DRIVER			
OTHER VEHICLE		YR _____		MAKE _____		MODEL _____	
LIC # _____		VIN # _____					
NAME							
OWNER / ADDRESS						PHONE	
DRIVER (<i>if not owner</i>) / ADDRESS						PHONE	
DESCRIBE DAMAGE							
OTHER VEHICLE INSURANCE CO.						POLICY #	
INSURANCE AGENT / ADDRESS						PHONE #	

Date Signed

Signed By

Title

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