

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.

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"/> 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 #
INJURIES (<i>complete separate form for each injured individual</i>)					
NAME			STUDENT/EMPLOYEE/OTHER		
LAST	FIRST	MIDDLE	GENDER		AGE
ADDRESS		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
NON-VEHICLE PROPERTY DAMAGE / LOSS					
PROPERTY DESCRIPTION / DAMAGE					
OWNER				EST. LOSS \$	
ADDRESS			PHONE		DIST. EMPLOYEE YES NO
DAMAGE TO DISTRICT VEHICLE / OR OTHER VEHICLE (<i>attach state accident report if available</i>)					WORK
DISTRICT VEHICLE <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	
OTHER VEHICLE YR		MAKE		MODEL	
				LIC #	
				VIN #	
DRIVER NAME / ADDRESS				PHONE	
OWNER NAME / ADDRESS				PHONE	
DESCRIBE DAMAGE					
OTHER VEHICLE INSURANCE CO.				POLICY #	
INSURANCE AGENT / ADDRESS				PHONE #	

Washington Schools Risk Management Pool • PO Box 88700 • Tukwila, WA 98138-2700
(206) 394-9737 • 800-488-7569 • FAX (206) 394-9712 • incident_report@wsrmp.com