

The School Board of Brevard County
RISK MANAGEMENT ACCIDENT/INCIDENT REPORT

(A copy of this report is not authorization for medical treatment.)



INSTRUCTIONS: ALL MUST COMPLETE SECTIONS 1 & 2...

- ⇒ If **Workers' Compensation claim**, complete sections 3, 6, 7 and 8 below. (3A and 3B must be completed.)
- ⇒ If **Student Accident/Incident, Visitor Accident/Incident, Employee/Student Problem/Issue or Theft claims**, complete sections 4, 6, 7 and 8 below.
- ⇒ If **Auto or District Property claim**, complete sections 5, 6, 7 and 8 below (as appropriate).

NUMERICAL SCHOOL/DEPT CODE

--

Please Print

1. SCHOOL/DEPARTMENT NAME

School/Department	<input type="checkbox"/> Work. Comp. <input type="checkbox"/> Student Accident <input type="checkbox"/> Prop Loss <input type="checkbox"/> Visitor Accident/Incident <input type="checkbox"/> Auto <input type="checkbox"/> Problem/Issue	Person Injured: <input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Student <input type="checkbox"/> Volunteer	Social Security No: - -
-------------------	---	--	----------------------------

2. ACCIDENT

Date of Loss: MM/DD/YY / /	Time of Loss: : AM <input type="checkbox"/> PM <input type="checkbox"/>	Location of Loss (Be specific, ie: Room 13's closet):
-------------------------------	---	---

3. CLAIMANT (WORKERS' COMPENSATION CLAIMS)

Name of employee:	Date of Birth: / /	Occupation & Department:	Part of Body Injured:	Type of injury (Cut, Sting, Bump, Bruise, Etc.)
Address:		City:	ST:	Zip: ()
3A-Does Employee wish to seek medical attention today: <input type="checkbox"/> Yes <input type="checkbox"/> No A "No" answer above does not waive the employee's right to request medical attention at a later date.		If "Yes", Designate referral (Name of Physician, Clinic, Hospital):		3B-Will Employee require time off from work: <input type="checkbox"/> Yes <input type="checkbox"/> No
		3C-Date injury first reported:		Return to work date: Time injury first reported:

4. CLAIMANT (Student Accident/Incident, Visitor Accident/Incident, Employee/Student Problem/Issue or Theft Reports)

Name:	Date of Birth: / /	Describe injury, problem/issue, damaged or stolen property:			
Address:		City:	ST:	Zip: ()	Phone No: ()

5. PROPERTY (DISTRICT OWNED) Attach picture of damaged property, Police and/or Public Safety's report

Describe damaged or stolen property:	Estimated cost of damage or value of stolen item:

6. WITNESS(ES)

Name:	Address:	City:	ST:	Zip: ()	Phone No: ()
Name:	Address:	City:	ST:	Zip: ()	Phone No: ()

7. DESCRIBE ACCIDENT/INCIDENT (To be completed by claimant/student. If claimant/student is unable to write, ask the following questions then write their response.)

A. What were you doing when injury/loss occurred?

B. How did the injury, loss or problem occur? (If more space is needed for writing, use the back of this form.)

C. Name of individual (s), equipment or other that directly injured, caused the loss or is creating a problem/issue?

8. SIGNATURE OF CLAIMANT/ADMINISTRATOR

Signature of Claimant:	Date: / /	Name of teacher(s)/employee(s) supervising the area (Please Print)	Date / /
Signature of Administrator:	Date: / /	Does Administrator agree with description of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Make one copy for the claimant, then send the ORIGINAL SIGNED DOCUMENT to Risk Management.