The School Board of Brevard County

RISK MANAGEMENT ACCIDENT/INCIDENT REPORT

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

NUMERICAL SCHOOL/DEPT CODE: 2211

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).
- ➪ **If 4 or 5 involve a criminal act**, attach the District Criminal Incident Report.

Please Print

1. SCHOOL/DEPARTMENT NAME

School/Department		Person Injured:	Social Security No:
Bayside High	❑ Work. Comp. ❑ Student Accident ❑ Prop Loss ❑ Visitor Accident/Incident ❑ Auto ❑ Problem/Issue	❑ Employee ❑ Visitor ❑ Student ❑ Volunteer	- -

2. ACCIDENT/INCIDENT

Date of Loss: MM/DD/YY	Time of Loss:	Location of Loss (Be specific, *ie: Room 13's closet*):
/ /	: AM ❑ PM ❑	

3. EMPLOYEE (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:	Phone No:
				( )

3A-Does Employee wish to seek medical attention today: ❑ Yes ❑ No A "No" answer above does not waive the employe'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: ❑ Yes ❑ No	Return to work date:
	3C-Date injury first reported:	Rate of Pay:	Time injury first reported:	Date of Hire:

4. STUDENT, VISITOR, EMPLOYEE (Non-work Injury) ACCIDENTS and INCIDENTS

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.

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 employee/student/or visitor. If they are 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

Signature of Student / Visitor / Employee:	Date: / /	Name of teacher(s)/employee(s) supervising the area **(Please Print)**	Date / /
Signature of Administrator:	Date: / /	Does Administrator agree with description of accident? ❑ Yes ❑ No	

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

NEITHER THE ORIGINAL OR COPY(S) OF THIS FORM SHALL BE KEPT IN THE DEPARTMENT OR SCHOOL.