

INSURANCE - INCIDENT REPORT

INCIDENT REPORTED BY:

Name	Position	Location	Date
TO:			

Name	Position	Signature
=====		

SUMMARY OF INCIDENT

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Time: \_\_\_\_\_

Name of person(s) injured: \_\_\_\_\_ Age: \_\_\_\_\_

If Minor, Parent/Guardian: \_\_\_\_\_ Tel# ( ) \_\_\_\_\_

If Property Damage is Incurred, Provide Contact Name, Telephone Number and/or Address:

Description of Incident and/or Property Damage Incurred:

Nature, extent of injuries:

Doctor, hospital where taken:

Parties Involved:

*** Witnesses	Address	Telephone #	Relationship/Duty
_____	_____	( ) _____	_____
_____	_____	( ) _____	_____
_____	_____	( ) _____	_____

\*\*\* ( ) A separate list of witnesses containing above information is attached.

REMINDERS: FOLLOW APPROPRIATE SMCPS POLICIES  
RETAIN RECORDS/NOTES

**Original: Send original to the CFO in the Fiscal Services Office. After processing to the MABE Claims Unit, the Fiscal Services Office will return a copy to the originator.**

FOLLOW-UP

Actions (indicate by whom):

Key dates for follow-up:

---

ATTACH THE COMPLETED STUDENT ACCIDENT FORM, WHERE APPLICABLE. PLEASE FORWARD TO US ANY POLICE INVESTIGATION REPORTS AS THEY BECOME AVAILABLE.

REMINDERS: FOLLOW APPROPRIATE SMCPS POLICIES  
RETAIN RECORDS/NOTES

**INSURANCE COORDINATOR (USE ONLY)**

Report Received: \_\_\_\_\_  
Date

Forwarded to MABE Claims Unit: \_\_\_\_\_  
Date

MABE Suggested Action: