

**This form is to be completed by the appropriate employee(s) as soon as possible after an accident occurs.
Please Print or Type.**

Claimant's Name _____		
<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>
Claimant's Address _____		
<i>City</i>	<i>State</i>	<i>ZIP Code</i>
Claimant's SS # _____	Home Phone Number (____) _____	
Claimant's Age _____	Date of Birth _____	Sex _____ Grade _____
Parent's Name (if student) _____		Work Phone Number (____) _____

Nature of Injury		Place of Accident		Body Part Injured		
<input type="checkbox"/> Scratch	<input type="checkbox"/> Concussion	<input type="checkbox"/> Classroom	<input type="checkbox"/> Gymnasium	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Leg
<input type="checkbox"/> Fracture	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Hallway	<input type="checkbox"/> Parking Lot	<input type="checkbox"/> Arm	<input type="checkbox"/> Face	<input type="checkbox"/> Nose
<input type="checkbox"/> Bruise	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Bathroom	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> Back	<input type="checkbox"/> Finger	<input type="checkbox"/> Teeth
<input type="checkbox"/> Burn	<input type="checkbox"/> Cut/Puncture	<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Stairs	<input type="checkbox"/> Neck	<input type="checkbox"/> Hand	<input type="checkbox"/> Wrist
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Bite	<input type="checkbox"/> Playground	<input type="checkbox"/> Athletic Field	<input type="checkbox"/> Eye	<input type="checkbox"/> Knee	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		

Is student covered by Student Accident Insurance? ☐ Yes ☐ No If “yes,” please list Company Name, address, and phone number

Date _____