◄ ◄ ◄ *Please print clearly and complete this multipage form in its* ***entirety*** ► ► ►

Mercer Island School District
Non-District Adult/Non-Student Accident Report Form

Please complete this accident report form and submit it to the Mercer Island School District ("District"). If you believe that the District is responsible for any loss, injury or damage please also submit a Damages Claim Form accessible online under Board Policy 6500P.

INSTRUCTIONS: Please: 1) Complete form, giving specific details about your accident or injury, including dates, times, and witnesses, if known; 2) sign the form; and 3) return form to the Business Services Department, attention Karen Hubbert, at

4160 86th Ave. SE
Mercer Island, WA 98040
206-236-3310
karen.hubbert@mercerisalndschooldistrict.org

The hours of operation are 8:00 am to 4:30 pm Monday through Friday, except for authorized holidays.

NOTICE: The District will not pay damages unless a claim complying with Washington State Law is presented to the District's Business Services Office. Please direct all questions to Karen Hubbert at ***206-236-3310***. Please be aware that some of the information submitted with this form may be subject to public disclosure pursuant to applicable law(s). For more information regarding claims, please refer to Board Policy 6500 and 6500P.

CLAIMANT: _____
First Middle Last

CLAIMANT'S PARENT/GUARDIAN: _____
(Provide if Claimant is under 18) First Middle Last

ADDRESS: _____
Street City State Zip Code

HOME PHONE: _____ WORK PHONE: _____ Date of Birth: _____

Pursuant to § 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSE"), please provide the following information:

ARE YOU CURRENTLY ELIGIBLE FOR OR COVERED BY MEDICARE? Yes _____ No _____

HAS THE INJURED PERSON BEEN ON SSDI FOR 2 OR MORE YEARS?: Yes _____ No _____

INCIDENT DESCRIPTION:

Date of the incident: _____ Time: _____ a.m./ p.m. (circle one)

(Continue)

If the incident occurred over a period of time, date of first and last occurrences:

from _____ Time: ____ a.m. /p.m. **to** _____ Time: ____ a.m. p.m.
(mm/dd/yyyy) (mm/dd/yyyy)

Incident Location: _____

1. Describe the conduct and circumstances that brought about the injury or damage. Also describe the injury or damage (attach an extra sheet for additional information, if needed).

_____
_____
_____
_____
_____
_____

2. Name(s) of Witnesses Address(es) Phone Number(s)

_____ _____ _____
_____ _____ _____
_____ _____ _____

3. Attach copies of all documentation relating to expenses, injuries, losses, and/or estimates for repair.

4. Have you submitted a claim for damages to your insurance company? Yes_____ No_____
If so, please provide the name of the insurance company:_____,
and the policy #: _____

5. The name and contact information of any doctor or medical professional seen for injuries allegedly sustained.

6. If Claimant received medical treatment, total amount of unreimbursed medical bills $_____.
(Please attach all medical bills.)

ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY

License Plate #:_____ Driver License #: _____

Auto Type: Year_____ Make_____ Model_____

DRIVER: _____ OWNER: _____
Address: _____ Address: _____
_____ _____
Phone #: _____ Phone #: _____

PASSENGERS:
Name: _____ Name: _____
Address: _____ Address: _____
_____ _____