



ASCIP Alliance of Schools for Cooperative Insurance Programs

16550 Bloomfield Avenue • Cerritos, CA 90703 • PH: (562) 404-8029 FAX: (562) 404-8038 • www.ascip.org

CONFIDENTIAL-ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE

This report is to be completed by district employees. This form is a confidential, internal, document: its contents are not to be shared or copied for any persons who are not district employees and/or their legal representatives.

IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY.

DATE OF REPORT

NOTE: The district employee either witnessing the accident or supervising at the time should **complete and submit this form within 24 hours.** Please type or print using ball-point pen.

NAME OF SCHOOL DISTRICT/CCD 1 Mt. San Antonio College		NAME OF SITE 2	
ADDRESS OF SITE (NUMBER, STREET, CITY AND ZIP CODE) 1100 N. Grand Avenue, Walnut, CA 91789			
NAME OF INJURED PERSON (LAST, FIRST, M.I.) 3		AGE	GRADE
		TELEPHONE NUMBER OF INJURED PERSON ()	
IS INJURED PERSON A MINOR NO YES <input checked="" type="checkbox"/>	NAME OF PARENT OR LEGAL GUARDIAN		
ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE) 4			
WHERE DID ACCIDENT OCCUR 5		DATE (MONTH/DAY/YEAR)	TIME A.M. P.M.
DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS) 6			
FIRST AND LAST NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT 7		TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)	WAS HE PRESENT AT THE TIME YES NO
NAME OF WITNESS(ES) 8		ADDRESS	INJURED VIOLATED SCHOOL RULE YES NO STATUS (Student, Volunteer, etc.)
		TELEPHONE NO. ()	
		TELEPHONE NO. ()	
9 APPARENT NATURE OF INJURY (PLEASE CHECK) Abrasion Fracture Strain/Sprain Contusion Cut Dislocation Internal Concussion Other (explain) _____		10 INJURED PART OF BODY (PLEASE CHECK) Head Finger Arm Abdomen Neck Eye Leg Hand Back Chest Face Foot Other (explain) _____	
FIRST AID PROCEDURES USED 11		NAME OF PERSON WHO ADMINISTERED FIRST AID	
DISPOSITION OF INJURED AFTER ACCIDENT OR CLASS 12 Home Doctor Hospital Classroom		WHO WAS NOTIFIED 13	RELATIONSHIP TO INJURED
IF INJURED PUPIL LEFT SITE TO WHOM RELEASED 14		NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL/CCD 15	
STUDENT ACCIDENT BENEFITS AVAILABLE 16 YES NO	REMARKS 17		
NAME OF COMPANY			

For your protection California law requires the following to appear on this form. "It is unlawful to: (a) present or cause to be presented any false or fraudulent claim for payment of a loss under a contract of insurance; (b) prepare, make or subscribe any writing with intent to present or use the same, or allow it to be presented or used in support of such claim. Every person who violates any provision of this section is punishable by imprisonment in the State Prison not exceeding 3 years or by fine not exceeding \$1,000 or by both."

NAME OF PERSON COMPLETING REPORT 18		STATUS	TELEPHONE NUMBER OF PERSON ()
ADDRESS OF PERSON (NUMBER, STREET, CITY, STATE AND ZIP CODE)			PERSON WAS AN EYE WITNESS YES NO
SIGNATURE OF PERSON APPROVING REPORT		DATE SIGNED	

**Please send original to:
Risk Management - Bldg 4-2555**