

Date: _____

INCIDENT REPORT - SCHOOL EMPLOYEE/BOARD PROTECTION PROGRAM

School District: _____ County: _____

Superintendent: _____ Telephone: _____

Address: _____ City: _____ Zip: _____

Who is claim being made (or likely to be made) against? _____

Address: _____

Work Phone: _____ Home Phone: _____ Soc Sec # _____

Currently associated with school district in what capacity?

Certified Employee	_____	Secretary	_____
School Nurse	_____	Student Teacher	_____
Teacher Aide	_____	Substitute Teacher	_____
Authorized Volunteer	_____	School Board Member	_____
Other	_____		

Date of claim or incident: _____ time: _____

Where incident occurred: _____

Brief description of incident: _____

Description of injuries or damage: _____

Name and address of person(s) claiming injury or damage: _____

Name and address of witness(es): _____

Please mail two copies of this report to

Dewane Hendrix, Coordinator
School Insurance
State Education Buildings, Room 102-B
4 Capitol Mall
Little Rock, Arkansas 72201