California Congress of Parents, Teachers (PTA)
NIAC Policy # 03293

Incident Report Form

CLAIMS REPORTING PROCEDURE

If you have a question concerning whether to report an incident or claim, call KNIGHT Insurance Services at 800-733-3036.

Complete all items to the best of your ability, sign and date page 2, and then:

1. Immediately fax or email this completed Incident Report Form to **KNIGHT Insurance Services**
   EMAIL: PTACA@Knightins.net FAX: 818-662-9312
2. Email a copy of the report to: California State PTA info@capta.org
3. Email a copy to the district PTA President
4. Keep a copy of the report for your files

Important: Retain any equipment or furniture which caused or contributed to an injury until it can be inspected by an insurance representative.

If a claim needs to be reported after business hours or on the weekend, call (866) 718-1947.
This number is reserved for true claims emergencies after business hours and weekends.

General Information

Name of PTA		District PTA	Council
Name of Contact		Title	
Street Address		City	State Zip
Business Phone # ( ) Ext.	Cell Home Phone (circle one) ( )	E-mail Address	

Incident Information

Date of Incident	Day of Week (circle one) Mon Tue Wed Thurs Fri Sat Sun	Time of Incident AM / PM	Did incident involve a vendor, concessionaire and/or service provider? ☐ Yes ☐ No *(if yes, complete information on bottom of page 2)*
Location of Incident (if possible, take pictures of the area with a digital or disposable camera)			
Description of Incident (A brief factual account of the incident; include who was involved, how the incident occurred and what action is being taken in response to the incident. Use the back of the sheet if more space is needed.)			
Was injury due to any act or negligence of PTA? ☐ Yes ☐ No If yes, explain:			
Was activity under the supervision and/or sponsorship of PTA? ☐ Yes ☐ No If yes, explain:			
Was this activity approved by the PTA membership? ☐ Yes ☐ No			

Witness Information

	Name and Address	Daytime Phone	Email Address	DOB
1.				
2.				

Claimant Information (if any; attach additional sheets if more than one)

Name of Injured Party	DOB	☐ Employee ☐ Client ☐ Volunteer ☐ Visitor ☐ Other –

Address – Street	City	State	Zip

Home Phone #	Business Phone #	Email Address
( )	( )	

Description of Injury (nature and extent of; please be specific):

Transported by Ambulance	Name and Phone # of Hospital or Doctor, if applicable
☐ Yes ☐ No	

What were injured party's duties (if any) in the activity? (please be specific):

Your Observations

Claimant's Attire/Description of Clothing (i.e., shorts, t-shirt)	Type of Shoes	Was Claimant carrying anything? (if yes, what) ☐ No ☐ Yes –

Describe claimant's demeanor when making the report (i.e., agitated, in obvious or no obvious pain, able to move around while describing what happened, etc.)

(use the back of the form or attach an additional sheet of paper if needed)

IF EVENT INVOLVED A VENDOR/CONCESSIONAIRE/SERVICE PROVIDER

Name:		Phone Number: ( )	
Street Address:	City	State	Zip

(attach copy of the vendor's insurance and hold harmless agreement))

PERSON IN CHARGE

Full Name:		Phone Number: ( )	
Street Address:	City	State	Zip

PERSON COMPLETING THE REPORT

Full Name:		Phone Number: ( )	
Street Address:	City	State	Zip

SIGNATURE OF INDIVIDUAL COMPLETING THE REPORT **DATE**