ETB Accident Report Form

Important note: This form should be completed by a teacher/administrator in the ETB and not the injured person. If the accident was caused by a piece of equipment, please retain for inspection should the need arise.

Please make sure that the information you give is as clear and complete as possible.
Please complete in BLOCK CAPITALS or on-line save and print.

1. Policyholder Details

Name of ETB: Telephone No:

Policy No:

2. Accident Details

Location:

GPS Co-ordinates: Latitude Longitude (decimal degrees)

Date: Time:

3. Injured Person Details

Name:

Address:

Age:

Nature of Injury:

Did injured person require medical treatment: Yes ☐ No ☐ Are injuries ongoing: Yes ☐ No ☐

If 'Yes', please give further details:

If 'Yes', state the name and address of the doctor/hospital:

4. Details of Teacher in charge of Injured Person

Name:

Address:

Position:

5. Accident Details

This should include the nature of the activity in which the injured person was engaged when the accident occurred and whether the teacher was present.

Names and Addresses of any witness(es):

	Witness 1	Witness 1	Witness 1
Name:			
Address:			

Name of the person to whom the accident was first reported:

Date: By whom:

Has any claim been made against the ETB: Yes ☐ No ☐ Date:

If 'Yes', please give details:

6. Declaration

IPB Insurance is classified as a Data Controller under Irish Data Protection Legislation. The information you provide to us as part of your claim application will be processed by us to confirm your identity, process your application and to record and cross reference particulars of your claim in insurance industry databases for fraud prevention purposes. This may involve exchanging information with Insurance Link, the anti-fraud claims database run by the Irish Insurance Federation. In certain cases we may also share your information with other insurance providers and private investigators.

I/We hereby declare that the statements on this form and the information provided in addition are true and complete, to the best of my/our knowledge and belief

Signature of Teacher/Administrator: Date:

Signature of Principal/ Vice Principal: Date:

Please return completed form to:

The Claims Department
IPB Insurance
1 Grand Canal Square, Grand Canal Harbour, Dublin D02 P820, Ireland.
Tel: +353 1 639 5500 Fax: +353 1 639 5540 Email: claims@ipb.ie Web: www.ipb.ie