

INCIDENT REPORT

Risk Management Use Only: Town Incident # _____

Liability: Property Loss/Damage: _____ Auto Loss/Damage: _____

SECTION I

(Complete in full)

Incident Information

Reporting Date: _____ Date of Incident: _____

Location of Incident: _____

City: _____ State: _____ Zip: _____

Type of Loss: (Auto, Property, Injury, Fire, Wind, Etc.) _____

Describe what happened

Employee Involved in Incident: _____

Contact Person for Additional Information: _____

Witness/Passenger Name(s): _____

Address: _____ Phone # _____

Was a Police Report Filed: Yes: No: If yes, Report # _____

Where Filed: _____

SECTION II

(Complete Section A and B)

A. Municipal Vehicle Information (For Auto/Motorized Equipment Loss/Damage)

Plate: _____ VIN: _____ Vehicle # _____

Year: _____ Make: _____ Model # _____

Driver's Name: _____ Department: _____

Describe Damage:

Where can vehicle be seen? _____

B. Other Vehicle Information

Year: _____ Plate: _____ VIN: _____

Make: _____ Model: _____

Owner's Name: _____

Address: _____ Phone: _____

City, State, Zip: _____

Driver's Name: _____

Address: _____ Phone: _____

City, State, Zip: _____

Describe how accident occurred:

Describe Damage:

SECTION III

(Complete Section A and B)

For other Municipal Losses

A. Property Loss/Damage:

Owner's Name: _____

Address: _____ Phone: _____

City, State, Zip: _____

Description of Lost/Damaged Property:

If Town Owned: Serial Tag # _____ Estimated Damage: _____

Repair: _____ Replace: _____

B. Injury/Incident:

Injured Name: _____

Address: _____ Phone: _____

City, State, Zip: _____

Nature & Extent of Injury/Accident:

Exact Location of Injury/Accident:

Cause of Injury/Accident:

Was person given first-aid? Yes: No:

If yes, describe first-aid treatment administered:

Sent for medical treatment: Yes: No:

If Yes, where? _____

FOR PARKS AND RECREATION USE ONLY:

Age of participant: _____ Parent/Guardian Name: _____

Program Name: _____ Location: _____

Program Supervisory Ratio: _____ No. of Program Participants: _____

Fill in where applicable:

___ Attended by Doctor: Name: _____ Time: _____

___ Removed to Hospital Name: _____ Time: _____

___ Parents Notified Name: _____ Time: _____

___ Parent/Person who picked up child: Name: _____ Time: _____

PLEASE ATTACH COPY OF SIGNED WAIVER RELEASE FORM IF APPLICABLE

Reported by: _____ Date: _____

Department Head Signature: _____ Date: _____