County of Riverside Confidential
Incident/Accident Report
(For Use at County Sponsored Special Events ONLY)

SUBMIT FORM TO:
County of Riverside H.R.Safety Division
3403 10th Street • Riverside, CA 92501 Mail Stop 2170
Ph: 951.955.3520 FAX 951.955.9200
safetydivision@rivco.org

Photos Are Required and Should be Submitted with Report

DATE OF REPORT

NOTE (1): DO NOT USE THIS REPORT IF THE INJURED PERSON IS A COUNTY OF RIVERSIDE EMPLOYEE.
NOTE (2): The employee either witnessing the accident or supervising at the time, should complete and submit this form within 24 hours.

NAME OF INJURED (LAST, FIRST, M.I.)	AGE	PH NUMBER OF INJURED PERSON

IS INJURED PERSON A MINOR? ☐ YES ☐ NO → **NAME OF PARENT OR LEGAL GUARDIAN**

ADDRESS OF PERSON INJURED (NUMBER, STREET, APT#, CITY, STATE, ZIP CODE)

WHERE DID ACCIDENT/INCIDENT OCCUR? (Be specific, e.g. front steps, lobby, parking lot, etc…)	DATE:	TIME ☐ A.M. ☐ P.M.

DESCRIBE HOW ACCIDENT/INCIDENT OCCURRED (USE FACTS ONLY, EXCLUDE OPINIONS AND/OR ASSUMPTIONS). IF NECESSARY, USE ADDITIONAL SHEET(S).

NAME OF WITNESS(ES)	ADDRESS	TELPHONE NO.

EVENT LOCATION (Example: DATE FESTIVAL)

ADDRESS (NUMBER, STREET, CITY, ZIP CODE)	TELEPHONE NO.

APPARENT NATURE OF INJURY (PLEASE CHECK)

☐ Abrasion ☐ Fracture ☐ Strain/Sprain ☐ Contusion ☐ Dislocation ☐ Cut ☐ Other (please explain below)

FIRST AID PROCEDURES USED (IF ANY) and/or AED?	NAME OF PERSON WHO ADMINISTERED FIRST AID (IF KNOWN)

DISPOSITION OF INJURED AFTER INCIDENT/ACCIDENT (IF KNOWN) ☐ Home ☐ Doctor ☐ Hospital	WHO WAS NOTIFIED	RELATIONSHIP TO INJURED (IF KNOWN)

IF INJURED PERSON LEFT PREMISES, TO WHOM RELEASED	PHONE NUMBER (IF KNOWN)

How soon after incident was the location/area inspected?
Dry? ☐ YES ☐ NO Any puddles? ☐ YES ☐ NO Describe lighting
Describe location or condition

Does injured person wear glasses (if known)? ☐ YES ☐ NO Type and condition of shoes (if known)? ☐OLD ☐NEW Where were you when the incident occurred?
Did you see the incident? ☐ YES ☐ NO If so, describe:
Injured person's comments (if any) and attitude (if applicable)?:

PRINTED NAME AND TITLE OF PERSON COMPLETING REPORT: TELEPHONE NUMBER OF PERSON:	EMAIL ADDRESS:
BUISNESS ADDRESS:	WAS PERSON AN EYE WITNESS ☐ YES ☐ NO
SIGNATURE OF PERSON COMPLETING REPORT:	DATE SIGNED: