

County of Riverside Confidential Incident/Accident Report

County of Riverside • Safety Division

1111 Spruce Street • Riverside , CA 92507 • Mail Stop 2170 • 951.955.3520 • FAX 951.955.9200

Please use this form to - REPORT ALL INCIDENTS/ACCIDENTS
DO NOT Use this form to - REPORT EMPLOYEE (on-the-job) INJURIES

This Form Should be Provided to the Safety Division Within 48 Hour of any Incident/Accident

COUNTY DEPARTMENT INFORMATION**Mail Stop:**

Department:

Address:

City:

Zip:

Name of Contact Person:

Phone No:

Email Address:

INCIDENT INFORMATION (THIS SECTION MUST BE COMPLETE IRREGARDLESS OF THE AVAILABILTY OF A POLICE REPORT)

Date of Incident:

Time:

 AM PM

Location:

Address: (If Known)

City:

Zip:

Description of Incident or Accident: (FOR ADDITIONAL INFORMATION PLEASE USE SUPPLEMENTAL SHEET)

Witness(es):

Phone:

Identify Responding Agency (Police, Fire, Etc.)

Report #:

INJURIES

Gender

Age

Last

First

Middle

Address

Home Phone

Street

City

Zip Code

Name of Parent/Guardian (if applicable)

Work Phone

Part of Body Injured

Type of Injury (e.g., cut, burn)

Extent of Injury (e.g., minor, severe)

Name of Person in Charge at Time of Accident

Title

Phone

Present at Scene? Yes No

Action Taken/by Whom/When

Was 911 called?

Was injured person transported to hospital?

Was treatment offered but refused?

NON-VEHICLE PROPERTY DAMAGE/LOSS

Property Description/Damage

Owner

County Employee

Yes

No

Address

Home Phone

Work

DAMAGE TO COUNTY VEHICLE OR NON COUNTY VEHICLE (Attach Agency accident report if available)**VEHICLE 1** (County Vehicle) YR

Make

Model

License Plate .#

County Vehicle #

Driver Name

Office Phone:

Other (Home/Cell)Phone

Describe Damage

Citation/Violation (If known)

County Driver

Other Driver

Name

VEHICLE 2 (Other Party) YR

Make

Model

License Plate. #

Owner/Address

Work Phone

Home

Cell

Driver (if not owner)/Address

Work Phone

Home

Cell

Drivers License Number:

Date of Birth:

Describe Damage

Other Vehicle Insurance Co.

Policy #

Passenger Information Name

Address

Phone: Work

Home

Cell

Person Completing Form:**Signature:****Ph.:****Date:****Supervisor:****Signature:****Ph.:****Date:**

County of Riverside Confidential Incident/Accident Supplemental Report

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Mail Stop:

Name of Contact Person (Print)

Phone #

Email Address

INCIDENT INFORMATION

Date of Incident

Time

AM/PM

Location:

Address: (If Known)

City

Zip

Person Completing Form:

Signature:

Ph.:

Date:

Supervisor:

Signature:

Ph.:

Date: