

Town of Chino Valley

1020 West Palomino Road, Chino Valley, AZ 86323

INCIDENT REPORT

Page 1 of 3

Risk Management Use Only:

Town Incident #

Liability:

Property Loss/Damage:

Auto Loss/Damage:

SECTION I

(Complete in full)

1. 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 _____ Report # _____

Where Filed? _____

SECTION II

(Complete A, B or C)

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

Plate: _____ VIN: _____ Vehicle # _____

Year: _____ Make: _____ Model: _____

Driver's Name: _____ Department: _____

Describe Damage: _____

Where can Vehicle be Seen? _____

Town of Chino Valley

1020 West Palomino Road, Chino Valley, AZ 86323

INCIDENT REPORT

Page 2 of 3

B. Other Vehicle Information

Year: _____ Plate: _____ VIN: _____
Make: _____ Model: _____

Owner's Name: _____
Address: _____ Phone: _____

Driver's Name: _____
Address: _____ Phone: _____

Describe How Accident Occurred: _____

Describe Damage: _____

SECTION III

For Other Municipal Losses

A. Property Loss/Damage:

Owner's Name: _____
Address: _____ Phone: _____

Description of Lost/Damaged Property: _____

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

Town of Chino Valley

1020 West Palomino Road, Chino Valley, AZ 86323

INCIDENT REPORT

Page 3 of 3

B. Injury/Accident

Injured's Name: _____

Address: _____

Phone: _____

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? _____

C. **FOR PARKS & 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: _____

____ Parent 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: _____