



**COUNTY OF ALAMEDA
INCIDENT REPORT FORM
(FORM 430300-2)**

TO BE COMPLETED IMMEDIATELY OR AT THE EARLIEST OPPORTUNITY.

The County employee who witnesses or is directly involved in an incident (workplace safety, trips, slips or falls, **not** a vehicle accident or incident) should complete this form. Attach any photos or diagrams. The incident report form and any attachments should immediately be emailed to VAR_IRF@acgov.org or sent by QIC to 28505.

For vehicle accidents or vehicle incidents, complete Form 430300-1.

(Attach additional sheet if necessary)

DATE OF INCIDENT	DAY OF WEEK	TIME OF INCIDENT	
LOCATION OF INCIDENT			
BODILY INJURY INFORMATION	(1) Name of Injured:	Age:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
	Address:		
	Nature of Injury (Specify Injured Part(s) of the Body):	First Aid Procedures Used and by Whom:	
	(2) Name of Injured:	Age:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
	Address:		
	Nature of Injury (Specify Injured Part(s) of the Body):	First Aid Procedures Used and by Whom:	
PROPERTY DAMAGE INFORMATION	What was damaged?	Where can damaged property be seen?	
	Describe in detail the property damages:		
	Who is the Owner?	Owner's Address:	Owner's Phone #:
PHOTOGRAPHS Were there any taken? <input type="checkbox"/> Yes <input type="checkbox"/> No → If "YES" By Whom? Phone #:			
IF THERE WERE ANY WITNESSES, PLEASE PROVIDE THE FOLLOWING INFORMATION			
(1) Witness Name:	Address:	Work Phone:	Home Phone:
(2) Witness Name:	Address:	Work Phone:	Home Phone:
(3) Witness Name:	Address:	Work Phone:	Home Phone:

DESCRIBE IN DETAIL THE INCIDENT:	
HOW COULD THIS INCIDENT HAVE BEEN PREVENTED?	
ADDITIONAL REMARKS:	
REPORTING EMPLOYEE'S NAME, TITLE: (Print or Type Below)	Phone #:
EE's Signature _____ Date: _____	
REPORTING EMPLOYEE'S SUPERVISOR'S NAME, TITLE (Print or Type Below)	Phone #:
Supervisor's Signature _____ Date: _____	