



CITY OF SAN ANTONIO

Citizen Incident Report

Citizen Injury _____

POV Collision* _____

Other Incident Type _____

(*Not Involving COSA Vehicle)

MUST be completed and submitted to Risk Management within one business day of notice of incident.

DEPT. CODE # (Required)

FOR RISK MGMT USE

PERSON(S) INVOLVED (DEPARTMENT SUPERVISOR TO COMPLETE)			INCIDENT/INJURY INFORMATION		
1. Involved/Injured Persons Name (Last, First, M.I.):		2. Date of Birth: (mm/dd/yyyy): / /	17. Date of Incident/Injury: (mm/dd/yyyy): / /	18. Time of Incident/Injury: AM PM	19. Street Conditions: Dry ___ Wet ___ Icy ___ Other ___
3. Sex: F ___ M ___	4. Is Involved/Injured person a minor? Yes ___ No ___	5. Involved/Injured's age:	20. Address/Location where Incident/Injury occurred:		
6. Mother/Guardian's Name: NA ___		7. Father/Guardian's Name: NA ___	21. Specific location (stairwell, lobby, etc..) at address where Incident/Injury occurred:		
8. Involved's home/primary phone #: () -	9. Parents' home/primary phone numbers: NA ___ Mother () - Father () -		22. Reported by whom:		
10. Involved/Injured's home address:			23. Describe Incident: (Additional space available on reverse side.)		
11. Involved/Injured's marital status: NA ___ Single ___ Married ___ Divorced ___ Widowed ___ Unknown ___			24. If Injured is a minor, were they supervised? Yes ___ No ___ NA ___ UNK ___		
12. Emergency Contact Name: NA ___		13. Emergency Contact/primary phone #: () -	25. If Yes, By whom? (Name of person?)		
14. Were there any witnesses: Yes ___ No ___ NA ___ Unknown ___	15. List witnesses' names and phone numbers:		26. Type of Incident (S/T/F, Jumping From/To, Running/Walking, Vehicle Collision, Bike Riding, etc):		
16. Other important information about involved/injured, parent(s), guardian(s), etc.			27. Nature of Injury: No Injury ___ First-Aid Provided ___ Other ___	28. If First-Aid was provided, by whom: NA ___	
			29. Part(s) of Body Injured: NA ___	30. Type of Injury (Circle that apply): NA ___ Scrape Pinch Sprain Burn Cut Fracture Crush Loss Consciousness Other: _____	
			31. Was an ambulance called: Yes ___ No ___ NA ___	32. If Yes, By whom: NA ___	
			33. Did the injured party seek medical attention: Yes ___ No ___ NA ___	34. If Yes, provide date: NA ___	
			35. If Medical Treatment was administered, provide clinic or doctor name (if known): NA ___ Unknown ___ Clinic / Doctor _____		

Complete below if incident relates to Citizens Vehicle (POV) Accident/Collision

(POV struck COSA employee, struck and damaged COSA property, and/or similar)

CITIZEN/POV COLLISION			
36. POV Collision with (Struck): COSA Employee(s) ___ With COSA property ___ Other ___		37. SAPD Responded: Yes ___ No ___	38. SAPD Accident Report Completed: Yes ___ No ___
39. Case #		40. Name(s) of Citizens Also Involved in Collision: (Use box 16 above if needed)	
41. Responding Officer's Name:		42. Responding Officer's Badge #:	
43. Brief Description of Incident: (Provide photos of incident, damage, etc. - Additional space available on reverse side.)		44. Brief Description of Injury(s) or Property Damage: (If COSA employee injured, Supervisor to complete "Supervisor Report of Injury or Illness")	
45. Name of Owner/(Driver) of Vehicle: License Plate # Driver's License #		45. Owner's/Driver's Phone Number:	
47. Insurance Company Name and Phone Number:		48. Policy Number:	

