

**INCIDENT REPORT**

**MEMBER CITY/ORGANIZATION:** CITY OF BURLINGTON Date: \_\_\_\_\_

This report shall be completed by the person who was present at the time the incident occurred or was discovered. Information is to be recorded immediately and the form forwarded to the Member's Claims Contact Person who will then forward a copy to Washington Cities Insurance Authority.

Name(s) of Member Personnel Involved \_\_\_\_\_ Department \_\_\_\_\_ Phone \_\_\_\_\_

Name(s) of OTHERS Involved \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time: \_\_\_\_\_

Location (Physical address of occurrence): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Describe all acts and resulting conditions in detail: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What active measures, or assistance (if any) did Member Employees take? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Reported by \_\_\_\_\_ Date Signed \_\_\_\_\_

Department \_\_\_\_\_

**SUBMIT FORM WHEN COMPLETED TO RISK MANAGER**

**Received by Shelley Acero – Risk Manager** \_\_\_\_\_