



# LOS ANGELES COMMUNITY COLLEGE DISTRICT INCIDENT/INJURY REPORT

 <p style="font-size: small; margin: 0;">Los Angeles Community Colleges 770 Wilshire Boulevard Los Angeles, CA 90017 In partnership with the Los Angeles County Sheriff's Department</p>		Date and Time Incident Occurred:	Name of College Campus:	Incident No.:
		Date and Time Reported to Sheriff's Department:	Location on Campus Where Incident Occurred:	
Type of Incident: <input type="checkbox"/> Employee <input type="checkbox"/> Student <input type="checkbox"/> Student Worker <input type="checkbox"/> Visitor <input type="checkbox"/> Non-Criminal Graffiti <input type="checkbox"/> Traffic Incident				

CODE:    ST-STUDENT    EM-EMPLOYEE    W-WITNESS    I-INFORMANT    DP-DISTURBING PARTY    M-PATIENT    P-PARTY

PARTY INJURED/INVOLVED IN INCIDENT											
Party's Name (Last, First Middle):			Party's Address:			Party's Telephone No.		Party's Employee Number:		Party's Driver's License No.	
Sex:	Race:	Date of Birth:	Age:	Height:	Weight:	Hair Color:		Eye Color:			
Type of Injury ( <i>Industrial, Accident</i> ):			Extent of Injury ( <i>Minor or Serious</i> ):			Transported to:			Transported by:		
Supervisor's/Instructor's Name:			Supervisor's/Instructor's Telephone Number:			Supervisor/Instructor Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date and Time Notified:			
Date DWC-1 Form Issued:						Date Medical Referral Issued:					

WITNESSES/OTHERS INVOLVED											
Code	No. of	Last Name	First Name	Middle Name	DOB	Sex	Race	Hair	Eyes	Height	Weight
Res. Address			City		Zip	Driver's License		State	Res. Phone (w/area code)		
Bus. Address			City		Zip	Bus. Phone		Prior Contact <input type="checkbox"/> Yes <input type="checkbox"/> No			

Code	No. of	Last Name	First Name	Middle Name	DOB	Sex	Race	Hair	Eyes	Height	Weight
Res. Address			City		Zip	Driver's License		State	Res. Phone (w/area code)		
Bus. Address			City		Zip	Bus. Phone		Prior Contact <input type="checkbox"/> Yes <input type="checkbox"/> No			

Code	No. of	Last Name	First Name	Middle Name	DOB	Sex	Race	Hair	Eyes	Height	Weight
Res. Address			City		Zip	Driver's License		State	Res. Phone (w/area code)		
Bus. Address			City		Zip	Bus. Phone		Prior Contact <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>Party's Statement</b>	
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<b>Physical Observations</b>	
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Reporting Officer	Date and Time Received	Person Reporting Incident ( <i>Print</i> )	Person Reporting Incident ( <i>Signature</i> )
Reporting Officer's Signature		Approving Supervisor	Division - Clerk

REFERENCE: LACCD EH&S RR-03

**Fax a Copy to the District's Risk Management Office  
Hand Deliver the Original to the College Focal Point  
TO BE COMPLETED BY SHERIFF**

