

City of Hokah
102 Main Street
PO Box 311
Hokah, MN 55941

MUNICIPAL INCIDENT REPORT

Type of Incident: ___ Injury ___ Rescue ___ Accident ___ Disturbance

DATE: _____ TIME REPORTED: _____

Incident Time: _____ am/pm. EMS Called ___ Yes ___ : ___ Time ___ No

Incident Location: _____

People Involved:

Complainant	Injured	Parent(s)
Name:	Name:	Name:
Address:	Address:	Address:
Phone #:	Phone #:	Phone #:
Work or Cell #:	Work or Cell #:	Work or Cell #:

Others Involved:

Witness	Injured	Parent(s)
Name:	Name:	Name:
Address:	Address:	Address:
Phone #:	Phone #:	Phone #:
Work or Cell #:	Work or Cell #:	Work or Cell #:

Narrative:

Use Back of this form if necessary

Signatures:

Employee: _____ Supervisor _____

Office Use Only:

Date Received: _____ Resolved ___ Yes ___ No Pending ___ Yes ___ No

Action Taken: _____

PLEASE RETURN COMPLETED FORM TO CITY ADMINISTRATOR'S OFFICE