LOMPOC FIRE DEPARTMENT
REQUEST FOR INCIDENT REPORT

Please read the information on page 2 of this form before completing

Incident Date: ______________________________

Incident Address: ______________________________

Incident Type: Fire Medical Other

PERSON AND BUSINESS OR AGENCY REQUESTING REPORT:

Name (first, middle initial, and last): ______________________________

Business Name: ______________________________

Mailing Address: ______________________________

City: ____________________ State: ________ Zip: ____________

Daytime Phone Number: ______________________________

Email Address: ______________________________

REQUESTING PARTY IS THE:

Owner
Owner's Insurance Agent
Owner's Attorney
Occupant/Tenant
Occupant/Tenant's Insurance Agent
Occupant/Tenant's Attorney

Patient
Patient's Legal Guardian
Patient's Insurance Agent
Patient's Attorney/Legal Representative
Patient's Spouse
Beneficiary of Deceased Patient
Other ____________________

FOR INSURANCE COMPANY REPRESENTATIVES:

Insurance Company Name: ______________________________

Person(s) you represent: ______________________________

Policy/Claim Number(s): ______________________________

SIGNED: ______________________________ DATE: ____________________

------------------------------ **(For Office Use Only)** ------------------------------

- ☐ Photocopy of patient's/authorizing party's identification attached (all medical information)
- ☐ Authorization for release attached (medical information release as required)
- ☐ Self-addressed, stamped envelope attached
- ☐ Check attached

Incident Number: ______________________________
Received by (Print Name): ______________________________
Received by (Signature): ______________________________ Date: ____________
Authorized by (Fire Dept. Rep's Signature): ______________________________ Date: ____________

REQUEST FOR INCIDENT REPORT - INSTRUCTIONS

Mail Requests and Checks To: Lompoc Fire Department
115 South G Street
Lompoc, CA, 93436
Telephone: 805-736-4513

Please include a self-addressed stamped envelope.

General Information

FEE: $10.00. All related fees must be paid before a request can be released. Make check or money order payable to the City of Lompoc.

Medical Incident Reports - Medical information is strictly confidential and cannot be released to anyone other than the patient unless the patient has signed a release of information document authorizing the second party to obtain the medical incident report. Patient will be required to present valid identification. A copy of this identification will be attached to your request for our files.

To receive your report by mail, please enclose a self-addressed stamped envelope. Otherwise, you will be notified when your report is ready for pick up. A RESPONSE CAN TAKE UP TO 10 WORKING DAYS.

Completing This Form

YOU CAN DOWNLOAD AND COMPLETE THIS FORM ELECTRONICALLY USING THE ACROBAT READER, AND THEN PRINT IT, OR YOU CAN PRINT THE FORM AND COMPLETE IT MANUALLY.

PLEASE PRINT ALL INFORMATION. · Provide the date and the address where the incident occurred. Indicate whether the incident involved a fire, medical assistance, or something other than the two types listed.

Print your first, middle, and last name. (Name of requesting party)· If applicable, print the name of the business or agency you represent and the mailing address. Indicate your relationship with or involvement in the incident as
the requesting party. If you represent an insurance company, give the name of your insurance company, the name of the person you represent, and the policy/claim number.