

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

**“HOW AM I DRIVING PROGRAM”  
INCIDENT REPORT**

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Vehicle Description: \_\_\_\_\_

License Plate #: \_\_\_\_\_ Vehicle #: \_\_\_\_\_

**Driver's Name:** \_\_\_\_\_ **Employee #:** \_\_\_\_\_

\_\_\_\_\_  
Supervisor's Name Supervisor's Title

\_\_\_\_\_  
Supervisor's Signature Date

Description of Incident: \_\_\_\_\_

\_\_\_\_\_

Findings: \_\_\_\_\_

\_\_\_\_\_

Action Taken: \_\_\_\_\_

\_\_\_\_\_

Action Approved By: \_\_\_\_\_

\_\_\_\_\_  
Chief, Administrative Support Bureau Date

(FOR ASB USE ONLY)

\_\_\_\_\_ Date Submitted to Supervisor

\_\_\_\_\_ Date Received from Supervisor

PLEASE RETURN WITHIN FIVE BUSINESS DAYS