


 ...in pursuit of good health
**EMS VEHICLE COLLISION
 AND
 PERSONAL INJURY REPORT FORM**

Send Original To Regional EMS Council:
 asnyder@lyco.org

This Report Must Be Filed Within 24 Hours of Incident and Within 8 Hours If Fatality Involved

Date Of Accident Mo Day Year	Day of the Week M T W Th F Sa Su <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hour-Military Time	Did Vehicle Driver Complete an EMSO Approved EVOC Course <input type="checkbox"/> Yes <input type="checkbox"/> No
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Service Info	Service Name:	Affiliate Number:	
	Name/Title of Person Completing Report:		
	Telephone:	E-mail:	Pager:
	Address:		
	City:	State:	Zip:

Veh. Info	EMSO Vehicle Decal Number:	Vehicle Drivable after Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No	VIN #:
	Approximate Damage Amount: <input type="checkbox"/> \$0-\$1,000 <input type="checkbox"/> \$1,000-\$5,000 <input type="checkbox"/> \$5,000-\$10,000 <input type="checkbox"/> \$10,000-\$25,000 <input type="checkbox"/> >\$25,000		

Accident Info	Number of Vehicles Involved:	Involved Collision With:	
	EMS: Other Emergency Service: Civilian:	<input type="checkbox"/> Animal <input type="checkbox"/> Natural Object (tree etc) <input type="checkbox"/> Fixed Object (pole etc) <input type="checkbox"/> Pedestrian <input type="checkbox"/> Bicycle	<input type="checkbox"/> Vehicle in Traffic <input type="checkbox"/> Overturned in Road <input type="checkbox"/> Parked Vehicle <input type="checkbox"/> Left Road-No Impact <input type="checkbox"/> Other:
	Impact Type:		
	<input type="checkbox"/> Front to Rear <input type="checkbox"/> Sideswipe <input type="checkbox"/> Rollover	<input type="checkbox"/> Broadside <input type="checkbox"/> Head-On <input type="checkbox"/> Other	
	Street Name or Route Number where Accident Occurred:		MCD Code Where Accident Occurred:
	Nearest Intersection or Mile Marker:		Number of Lanes:
	Did Incident Occur at Intersection: <input type="checkbox"/> Yes <input type="checkbox"/> No	Approximate Speed Prior to Incident: <input type="checkbox"/> 0-10 <input type="checkbox"/> 10-25 <input type="checkbox"/> 25-35 <input type="checkbox"/> 35-45 <input type="checkbox"/> 45-55 <input type="checkbox"/> 55-65 <input type="checkbox"/> >65	
	Traffic Controls: <input type="checkbox"/> Stop Sign <input type="checkbox"/> Yield Sign <input type="checkbox"/> Signal Light <input type="checkbox"/> Other Warning Sign/Signal		
	If at Traffic Signal-Signal Facing EMS Vehicle at Time of Incident: <input type="checkbox"/> Red <input type="checkbox"/> Yellow <input type="checkbox"/> Green		
	Weather: <input type="checkbox"/> Clear <input type="checkbox"/> Foggy <input type="checkbox"/> Cloudy <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> Ice	Light Conditions: <input type="checkbox"/> Daylight <input type="checkbox"/> Dark-Road Lighted <input type="checkbox"/> Dusk/Dawn <input type="checkbox"/> Dark-Road Unlighted	Road Surface: <input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Icy <input type="checkbox"/> Snow
Warning Devices In Use: <input type="checkbox"/> Visual (Red Lights) <input type="checkbox"/> Audible (Siren) <input type="checkbox"/> Headlights Only <input type="checkbox"/> None			
Mode of Service at Time of Incident: <input type="checkbox"/> Responding to Emergency <input type="checkbox"/> Responding to Non-emergency <input type="checkbox"/> Parked at Incident <input type="checkbox"/> Routine Driving <input type="checkbox"/> Training			
<input type="checkbox"/> Transporting Patient-Emergency <input type="checkbox"/> Transporting Patient-Non-Emergency <input type="checkbox"/> Parked-Other than at Incident <input type="checkbox"/> Backing <input type="checkbox"/> Other:			

<i>Description of the Event:</i>						
<i>*The Following Injury Reports must be completed for all EMS personnel and other injured in this vehicle.</i>						
Injury Info	Injury A					
	EMS: <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Ejected <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury Severity: <input type="checkbox"/> Fatal <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> Minor	Restraint System: <input type="checkbox"/> Safety Belt <input type="checkbox"/> Air Bag Deployed <input type="checkbox"/> Child Restraint <input type="checkbox"/> Other	Position in Vehicle: Enter # _____
	Injury B					
	EMS: <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Ejected <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury Severity: <input type="checkbox"/> Fatal <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> Minor	Restraint System: <input type="checkbox"/> Safety Belt <input type="checkbox"/> Air Bag Deployed <input type="checkbox"/> Child Restraint <input type="checkbox"/> Other	Position in Vehicle: Enter # _____
	Injury C					
	EMS: <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Ejected <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury Severity: <input type="checkbox"/> Fatal <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> Minor	Restraint System: <input type="checkbox"/> Safety Belt <input type="checkbox"/> Air Bag Deployed <input type="checkbox"/> Child Restraint <input type="checkbox"/> Other	Position in Vehicle: Enter # _____
	Total Number of People Injured: _____		Fatality Involved: <input type="checkbox"/> Yes <input type="checkbox"/> No Number: _____			
# EMS Personnel Injured: _____		EMS Fatality: <input type="checkbox"/> Yes <input type="checkbox"/> No Number: _____				
Did Police Investigate This Incident: <input type="checkbox"/> Yes <input type="checkbox"/> No			Police Report Attached: <input type="checkbox"/>			
If Police Report Was Filed and Copy Not Attached Complete the Following						
Investigating Police Agency: _____						
Address: _____						
City: _____		State: _____		Zip: _____		
Citations Issued: <input type="checkbox"/> Yes <input type="checkbox"/> No			Issued To: <input type="checkbox"/> EMS Driver <input type="checkbox"/> Other Driver			
Sign	I believe the information provided above to be accurate and correct:					
	Sign: _____ Title: _____ Date: _____					

Vehicle Position Identification Information:

- | | | |
|--------------------------------|----------------------------------|----------|
| 1=Drivers seat | 6=Captain's chair | 11=Other |
| 2=Front seat passenger | 7=Squad bench/seat | |
| 3=Squad bench seated | 8=Driver's side | |
| 4=Squad bench supine (patient) | 9=Litter | |
| 5=Backseat, squad unit | 10=Standing, patient compartment | |

***Use additional sheets as necessary if more than three injured individuals.**