

EMS VEHICLE COLLISION AND/OR PERSONAL INJURY REPORT FORM		Send Original To San Juan Island EMS PO Box 2178 Friday Harbor, WA 98250 360-378-5152 Office 360-378-3583 Fax		
<i>This Report Must Be Filed Within 24 Hours of Incident and Within 8 Hours If Fatality Involved.</i>				
Date Of Accident/Injury 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 Approved EVOC Course <input type="checkbox"/> Yes <input type="checkbox"/> No	
I. Service Information	Service Name: San Juan Island EMS		Affiliate Number: 28X02	
	Name/Title of Person Completing Report:			
	Telephone:	Email:	Pager:	
	Address:			
	City:	State:	Zip:	
	IF COMPLETING PERSONNEL INJURY REPORT ONLY PROCEED TO SECTION V			
II. Vehicle Info.	Vehicle 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 <input type="checkbox"/> Unknown			
III. Motor Vehicle Accident Incident Information	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"/> Side Impact <input type="checkbox"/> Sideswipe <input type="checkbox"/> Head-On <input type="checkbox"/> Rollover <input type="checkbox"/> Other			
	Street Name or Route Number 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 <input type="checkbox"/> Traffic pre-emption device (Opticom or EMS controlled)			
	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 With or Without spotter (circle one) <input type="checkbox"/> Other				

IV-Description	Description of the Event: <hr/> <hr/> <hr/> <p style="text-align: center;"><i>The following injury reports must be completed for all EMS personnel and others injured.</i></p>						
	Injury A						
V. Injury Information	EMS: <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Injury Severity: <input type="checkbox"/> Fatal <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> Minor	Injury Related To: <input type="checkbox"/> MVA <input type="checkbox"/> Fall <input type="checkbox"/> Needle stick <input type="checkbox"/> Lifting Patient <input type="checkbox"/> Ordinary Lifting	<input type="checkbox"/> Pedestrian Struck <input type="checkbox"/> Body Fluid Exp. <input type="checkbox"/> Hazardous Mat. <input type="checkbox"/> Assault <input type="checkbox"/> Other	Ejected <input type="checkbox"/> Yes <input type="checkbox"/> No	*Position in Vehicle if MVA: Enter # _____
	Injury B						
	EMS: <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Injury Severity: <input type="checkbox"/> Fatal <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> Minor	Injury Related To: <input type="checkbox"/> MVA <input type="checkbox"/> Fall <input type="checkbox"/> Needle stick <input type="checkbox"/> Patient Lifting <input type="checkbox"/> Ordinary Lifting	<input type="checkbox"/> Pedestrian Struck <input type="checkbox"/> Body Fluid Exp. <input type="checkbox"/> Hazardous Mat. <input type="checkbox"/> Assault <input type="checkbox"/> Other	Ejected <input type="checkbox"/> Yes <input type="checkbox"/> No	*Position in Vehicle if MVA: Enter # _____
	Injury C						
EMS: <input type="checkbox"/> Yes <input type="checkbox"/> No							
Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Injury Severity: <input type="checkbox"/> Fatal <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> Minor	Injury Related To: <input type="checkbox"/> MVA <input type="checkbox"/> Fall <input type="checkbox"/> Needle stick <input type="checkbox"/> Patient Lifting <input type="checkbox"/> Ordinary Lifting	<input type="checkbox"/> Pedestrian Struck <input type="checkbox"/> Body Fluid Exp. <input type="checkbox"/> Hazardous Mat. <input type="checkbox"/> Assault <input type="checkbox"/> Other	Ejected <input type="checkbox"/> Yes <input type="checkbox"/> No	*Position in Vehicle if MVA: Enter # _____	
Vi. Police Report Information	Did Police Investigate This Incident: <input type="checkbox"/> Yes <input type="checkbox"/> No			Police Report Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	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				
Vii. Sign	I believe the information provided above to be accurate and correct:						
	Sign: _____		Title: _____		Date: _____		

***Vehicle Position Identification Information:**

- | | | |
|--------------------------------|----------------------------------|----------|
| 1= Driver's 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.