



New York State  
Department of Health  
**Bureau of Emergency Medical Services**

**POLICY STATEMENT**

*Supercedes/Updates:* NEW

**No. 09 - 08**

**Date: July 8, 2009**

**Re: Reporting  
Incidents, Injuries and  
Crashes**

**Page 1 of 2**

The provision of prehospital emergency medical services inherently involves risk to the safety and health of providers, patients and the general public. All too frequently an EMS crew is involved in a “near miss” event or sustains actual injury. Because EMS providers are the most valuable part of the EMS system, the New York State Emergency Medical Services Council (SEMSCO), the State Emergency Medical Advisory Committee (SEMAC) and the Department’s Bureau of Emergency Medical Services (BEMS) have undertaken an examination of the practice of EMS response and prehospital care. This ongoing project is intended to promote a safe working environment and a **“culture of safety”**.

Title 10 New York State Codes, Rules and Regulations – Part 800.21(q) require the EMS service to report certain types of incidents to the Department within 24 hours of the event and in writing within five (5) business days. These incidents include:

- A patient death or injury due to the actions of the EMS provider
- A response vehicle crash
- Injuries to an on-duty<sup>1</sup> EMS provider requiring medical treatment
- The death of an EMS provider while on-duty.
- Patient care equipment failures that occur while being used to treat a patient and known to have caused harm to the patient or crew.
- It is alleged that any member of the ambulance service has responded to an incident or treated a patient while under the influence of alcohol or drugs while on duty.

In addition to the above mentioned circumstances, reportable incidents also include EMS response or on-duty related illnesses and exposures to infectious diseases or hazardous materials.

### **REPORTABLE INCIDENT FORM**

In an effort to better capture detailed information on EMS related injuries, illnesses and reportable events, the Department, with the assistance of the SEMSCO’s “Safety” Technical Advisory Group (TAG) have developed the attached Reportable Incident Form (DOH-4461).

This form must be completed for any incident in which serious injury, illness or death of an EMS provider, patient or other individual (for example, a bystander, driver of another vehicle) occurred in the course of their EMS response and/or duties. The form must be completed and returned to the appropriate BEMS Regional EMS Office within five (5) business days of the incident. A current list of regional office and EMS staff is available at <http://www.health.state.ny.us/nysdoh/ems/emsrep.htm>. This form does not take the place of any other local, state, federal or insurance required reporting form.

The form does not require the inclusion of individual identification or protected medical information and such materials should not be included when submitted to the Department. The information obtained on

<sup>1</sup> For the purposes of this Policy Statement, the term “on-duty” is defined as responding to a patient, treating and/or transporting a patient, assigned stand-bys and returning to service, the EMS station or residence.

the form will be collected in a database to be used to study events, incidents and injury trends with the intention to identify issues and solutions for change in order to make the EMS environment safer for its participants, the patients and the citizens of local communities. Additionally, the completed forms will be maintained by the Department.

As an important reminder, the Part 800.21(q) also requires that an EMS agency report any situation in which it is alleged that a member/staff of the EMS agency has responded to an incident or treated a patient while under the influence of alcohol or drugs while on duty must also be reported to the Department. This must be done in writing and sent to the appropriate BEMS Regional EMS Office within five (5) business days of the incident.

## FORM DIRECTIONS

The form is comprised of six (6) pages. It is only necessary to complete the pages that pertain to the specific incident being reported. If the incident requires additional description, use the appropriate supplemental pages provided. The pages of the form may be photocopied and attached as necessary. Additional copies of the form are available on the Department's web site at <http://www.health.state.ny.us/nysdoh/ems/emsforms.htm>.

Only complete and return sections that pertain to the incident being reported.

1. Please attach copies of any agency specific Incident Reports. Individual and/or protected medical information may be redacted.
2. If the type of injury, illness, or any other necessary information is not listed, Section 6 on page 6 must be completed. If multiple pages are necessary, this page can be photocopied.
3. Section 1 is for general information relating to the incident only and must be completed for all reporting. Only complete items in this section that pertain to the incident. Example: If no vehicle involved, do not complete that part.
4. Section 2 must be completed if an EMS crew member is injured or otherwise meets the reporting criteria.
5. Section 3 must be completed if a patient is injured or otherwise meets the reporting criteria.
6. Section 4 must be completed if another emergency responder (outside of your agency) or civilian is injured or otherwise meets the reporting criteria.
7. Section 5 must be completed if one or more vehicles were involved in the incident.
8. Section 6 must be completed only if additional documentation is necessary to describe this incident. Photocopies of this sheet can be utilized for additional documentation.
9. Supplemental Page 1 is only to be used to document additional EMS crew members injured or otherwise meets the reporting criteria.
10. Supplemental Page 2 is only to be used to document additional patients injured or otherwise meet the reporting criteria.
11. Supplemental Page 3 is only to be used if additional emergency responders (other than your crew), or civilians are injured or otherwise meet the reporting criteria.
12. Supplemental Page 4 is to be used as necessary to document additional vehicles involved with this incident.

## CONCLUSION

The submission of the Reportable Incident form is required should there be any serious injury, illness or death of an EMS provider, patient or other individual (for example, a bystander, driver of another vehicle) occurring in the course of their EMS response and/or duties. If there is a question as to whether a specific event meets the regulatory criteria, ***please complete and submit the form and documentation***. It is the SEMSCO and Department's goal to be able to study the information gathered so that the EMS community has a better understanding of the risks it faces and is able to work to build a safer EMS and patient care environment.

**Approved by Edward Wronski, Director**

This form must be completed for any serious injury, illness or death of an EMS provider, patient or other individual in accordance with Part 800.21(q) and 800.21(r). The completed form must be submitted to the New York State Department of Health's Bureau of Emergency Medical Services within 5 business days for every incident.

Name of EMS Service \_\_\_\_\_ NYS EMS Agency Code \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

Name of Contact Person and Title \_\_\_\_\_

Business Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Other Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**FORM DIRECTIONS**

**Only complete and return sections that pertain to the incident being reported.**

1. Please attach copies of any agency specific Incident Reports.
2. If the type of injury, illness, or any other necessary information is not listed, Section 6 on page 6 must be completed.  
**If multiple pages are necessary, this page can be photocopied.**
3. Section 1 is for general information relating to the incident only and must be completed for all reporting. Only complete items in this section that pertain to the incident. Example: If no vehicle involved, do not complete that part.
4. Section 2 must be completed if an EMS crew member is injured or otherwise meets the reporting criteria.
5. Section 3 must be completed if a patient is injured or otherwise meets the reporting criteria.
6. Section 4 must be completed if another emergency responder (outside of your agency) or civilian is injured or otherwise meets the reporting criteria.
7. Section 5 must be completed if one or more vehicles were involved in the incident.
8. Section 6 must be completed **only** if additional documentation is necessary to describe this incident. Photocopies of this sheet can be utilized for additional documentation.
9. Supplemental Page 1 is **only** to be used to document additional EMS crew members injured or otherwise meets the reporting criteria.
10. Supplemental Page 2 is **only** to be used to document additional patients injured or otherwise meet the reporting criteria.
11. Supplemental Page 3 is **only** to be used if additional emergency responders (other than your crew), or civilians are injured or otherwise meet the reporting criteria.
12. Supplemental Page 4 is to be used **as necessary** to document additional vehicles involved with this incident.

**This form does not replace any incident reporting forms required by a regional council, state or federal laws and regulation, and/or insurance policies.**

**SECTION 1****General Incident Information**

**Date of Incident** \_\_\_\_\_ **Time (24 Hour)** \_\_\_\_\_ **Day of Week** \_\_\_\_\_

**Your Agency Type** *(Check only one.)*

- Commercial     College     Fire Department     Independent  
 Industrial     Not-for-Profit     Municipal     Hospital

**Type of Incident**

- Illness     Injury     Injury During Response/Scene Operations     Injury During Training Operations  
 Other \_\_\_\_\_

**Location**

- Roadway     Residence     Commercial Site  
 Other \_\_\_\_\_

**Agency Status at Time of Incident**

- Available     On Scene     Parked (Staffed)  
 Responding     En-route to Hospital     Parked (Unstaffed)

**Weather Conditions at the Time of the Incident** *(Check all that apply.)*

- Daylight     Night     Dawn/Dusk  
 Clear     Fog     Rain     Snow     Ice  
 Other \_\_\_\_\_

**Motor Vehicle Involved**     Yes     No

- EMS Vehicle Involved:     Ambulance     ALS-FR     EASV     Other \_\_\_\_\_  
 Other Vehicle Involved:     Car     Truck     Other \_\_\_\_\_  
 Backing     Head-On     Sideswipe     Parked     Vehicle/Pedestrian     Vehicle/Responder

**Law Enforcement Response**     Yes     No**If Incident Occurred During Response, What Was the Patient Condition Based on Dispatch Information?**

- Minor     Moderate     Serious     Critical

**If Roadway**    Number of Lanes \_\_\_\_\_ *(All lanes. If road is bidirectional, count lanes for both directions.)*

- Intersection     Paved     Unpaved     Traffic Control Device  
 Private     Local     State     Interstate

**Road Conditions**

- Dry     Wet     Ice     Snow  
 Other \_\_\_\_\_

**Contributing Factors**

- Mechanical Failure     Drug/Alcohol Impaired (EMS Provider)  
 Broken Traffic Control Device     Drug/Alcohol Impaired (Other Party)  
 Other \_\_\_\_\_

**Number of Persons Involved**    \_\_\_ EMS Crew Member    \_\_\_ Patient    \_\_\_ Other Emergency Service    \_\_\_ Civilian

**Number of Persons Injured**    \_\_\_ EMS Crew Member    \_\_\_ Patient    \_\_\_ Other Emergency Service    \_\_\_ Civilian

**SECTION 2****Injured EMS Crew Member Information**

Complete this section for each injured EMS crew member. If more than one EMS crew member, use Supplemental Page 1.

Age \_\_\_\_\_  Male  Female

- |                                |   |  |
|--------------------------------|---|--|
| <input type="checkbox"/> CFR   | <input type="checkbox"/> EMT CC         | <input type="checkbox"/> Driver/Helper |
| <input type="checkbox"/> EMT   | <input type="checkbox"/> EMT P          | <input type="checkbox"/> Volunteer     |
| <input type="checkbox"/> EMT I | <input type="checkbox"/> EMS Supervisor | <input type="checkbox"/> Paid          |

 **Vehicle Operator**

- |   |  |
|---|--|
| <input type="checkbox"/> EVOC/CEVO Trained (Year _____) |  |
| <input type="checkbox"/> Restrained                     | <input type="checkbox"/> Working Outside Environment           |
| <input type="checkbox"/> Unrestrained                   | <input type="checkbox"/> Working Inside Building (Non-vehicle) |

 **Vehicle Occupant**

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Restrained   | <input type="checkbox"/> Working Outside Environment           |
| <input type="checkbox"/> Unrestrained | <input type="checkbox"/> Working Inside Building (Non-vehicle) |

**Mechanism of Injury**

- |  |   |
|--|---|
| <input type="checkbox"/> Animal Bite                 | <input type="checkbox"/> Fire                         |
| <input type="checkbox"/> Assault                     | <input type="checkbox"/> Hazardous Materials Exposure |
| <input type="checkbox"/> No Weapon                   | (Specify Product _____)                               |
| <input type="checkbox"/> With Weapon (Type _____)    | <input type="checkbox"/> Lifting/Bending              |
| <input type="checkbox"/> Carrying Equipment          | <input type="checkbox"/> Needle Stick                 |
| <input type="checkbox"/> Moving Patient              | <input type="checkbox"/> Pedestrian Struck            |
| <input type="checkbox"/> Transfer Onto/Off Stretcher | <input type="checkbox"/> Slip/Fall                    |
| <input type="checkbox"/> During Stretcher Transport  | <input type="checkbox"/> Structural Collapse          |
| <input type="checkbox"/> Electrical Injury           | <input type="checkbox"/> Toxic Inhalation             |
| <input type="checkbox"/> Explosion                   | <input type="checkbox"/> Other _____                  |

**Injury/Illness Description**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Respiratory    | <input type="checkbox"/> Death                | <input type="checkbox"/> Head Injury        | <input type="checkbox"/> Exposure        |
| <input type="checkbox"/> Cardiac        | <input type="checkbox"/> Fracture/Dislocation | <input type="checkbox"/> Spinal Injury      | <input type="checkbox"/> Heat            |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Laceration           | <input type="checkbox"/> Sprain/Strain      | <input type="checkbox"/> Cold            |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Burn                 | <input type="checkbox"/> Trauma Penetrating | <input type="checkbox"/> Exposure Hazmat |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Amputation           |   |  |

**Specify Body Part Affected**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Head                        | <input type="checkbox"/> Back   | <input type="checkbox"/> Leg ( <input type="checkbox"/> Left / <input type="checkbox"/> Right )  |
| <input type="checkbox"/> Neck                        | <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Hand ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Chest                       | <input type="checkbox"/> Arm ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) | <input type="checkbox"/> Foot ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Internal Organ/System _____ |   |  |

**Disposition: Admission**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Emergency Department Only  | <input type="checkbox"/> Critical Care Admission | <input type="checkbox"/> Personal Physician |   |
| <input type="checkbox"/> Hospital General Admission | <input type="checkbox"/> Deceased                | <input type="checkbox"/> None               | <input type="checkbox"/> Time Lost _____ (Days) |

**SECTION 3****Patient Information**

If more than one patient, use Supplemental Page 2.

Age \_\_\_\_\_  Male  Female

Pre-event Condition  Stable  Unstable  Critical

Post Event Injury Condition  Stable  Unstable  Critical

**Injury/Illness Description**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Respiratory    | <input type="checkbox"/> Death                | <input type="checkbox"/> Head Injury          | <input type="checkbox"/> Exposure        |
| <input type="checkbox"/> Cardiac        | <input type="checkbox"/> Fracture/Dislocation | <input type="checkbox"/> Spinal Injury        | <input type="checkbox"/> Heat            |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Laceration           | <input type="checkbox"/> Sprain/Strain        | <input type="checkbox"/> Cold            |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Burn                 | <input type="checkbox"/> Trauma Penetrating   | <input type="checkbox"/> Exposure Hazmat |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Amputation           | <input type="checkbox"/> Possible Cause _____ |  |

**Specify Body Part Affected**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Head                        | <input type="checkbox"/> Back   | <input type="checkbox"/> Leg ( <input type="checkbox"/> Left / <input type="checkbox"/> Right )  |
| <input type="checkbox"/> Neck                        | <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Hand ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Chest                       | <input type="checkbox"/> Arm ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) | <input type="checkbox"/> Foot ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Internal Organ/System _____ |   |  |

**Disposition: Admission**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Emergency Department Only  | <input type="checkbox"/> Critical Care Admission | <input type="checkbox"/> Personal Physician     |
| <input type="checkbox"/> Hospital General Admission | <input type="checkbox"/> Deceased                | <input type="checkbox"/> None                   |
|   |  | <input type="checkbox"/> Time Lost _____ (Days) |

**SECTION 4****Other Emergency Service Personnel (Firefighter, Police) or Civilian Information**

If more than one other emergency service personnel or civilian, use Supplemental Page 3.

Age \_\_\_\_\_  Male  Female

**Injury/Illness Description**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Respiratory    | <input type="checkbox"/> Death                | <input type="checkbox"/> Head Injury        | <input type="checkbox"/> Exposure        |
| <input type="checkbox"/> Cardiac        | <input type="checkbox"/> Fracture/Dislocation | <input type="checkbox"/> Spinal Injury      | <input type="checkbox"/> Heat            |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Laceration           | <input type="checkbox"/> Sprain/Strain      | <input type="checkbox"/> Cold            |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Burn                 | <input type="checkbox"/> Trauma Penetrating | <input type="checkbox"/> Exposure Hazmat |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Amputation           |   |  |

**Specify Body Part Affected**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Head                        | <input type="checkbox"/> Back   | <input type="checkbox"/> Leg ( <input type="checkbox"/> Left / <input type="checkbox"/> Right )  |
| <input type="checkbox"/> Neck                        | <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Hand ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Chest                       | <input type="checkbox"/> Arm ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) | <input type="checkbox"/> Foot ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Internal Organ/System _____ |   |  |

**Disposition: Admission**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Emergency Department Only  | <input type="checkbox"/> Critical Care Admission | <input type="checkbox"/> Personal Physician     |
| <input type="checkbox"/> Hospital General Admission | <input type="checkbox"/> Deceased                | <input type="checkbox"/> None                   |
|   |  | <input type="checkbox"/> Time Lost _____ (Days) |

**SECTION 5****Vehicle Information****Vehicle #1 (Ambulance) Information****Type of Vehicle**

- Type I                       Type III                       Sedan  
 Type II                       SUV                               EASV  
 Other \_\_\_\_\_

**Amount of Damage**

- Minor                               Severe                               Entrapment  
 Moderate                               Personal Injury                       Airbag Deployment  
 Vehicle Make \_\_\_\_\_ Vehicle Year \_\_\_\_\_ License Plate Number \_\_\_\_\_  
 Insurance Code \_\_\_\_\_ Last Maintenance Date \_\_\_\_\_  
 Emergency Lights at Time of Collision?  Yes  No                      Siren at Time of Collision?  Yes  No

**Ambulance Operator**

- Driver's Name \_\_\_\_\_ NYS EMT Number \_\_\_\_\_  
 Age \_\_\_\_\_  Male  Female      Hours on Duty \_\_\_\_\_  
 CFR                               EMT CC                               Driver/Helper  
 EMT                               EMT P                               Volunteer  
 EMT I                               EMS Supervisor                       Paid

**Reported to Duty From** (*Rested equals 8 hours of sleep.*)

- Home Rested                       Other Work Location Rested  
 Home Unrested                       Other Work Location Unrested

**Investigating Agency/Precinct**

- State Police                       Local Police Department  
 Sheriff                               Other \_\_\_\_\_  
 Law Enforcement Name, Barracks or Precinct \_\_\_\_\_  
 Report Number \_\_\_\_\_ Total Accident Damage Estimate (\$) \_\_\_\_\_

**Vehicle #2 Information**

*If more than one vehicle, use Supplemental Page 4.*

**Type of Vehicle**

- Sedan                               Truck (Semi)                       Other \_\_\_\_\_  
 SUV                               Truck (Straight)                       Other Emergency Vehicle \_\_\_\_\_  
 Pickup

**Amount of Damage**

- Minor                               Severe                               Entrapment  
 Moderate                               Personal Injury                       Airbag Deployment





*This page is intended to be used for documenting additional injured EMS crew members. Photocopy as necessary.*

**Age** \_\_\_\_\_  **Male**  **Female**

- |                                |   |  |
|--------------------------------|---|--|
| <input type="checkbox"/> CFR   | <input type="checkbox"/> EMT CC         | <input type="checkbox"/> Driver/Helper |
| <input type="checkbox"/> EMT   | <input type="checkbox"/> EMT P          | <input type="checkbox"/> Volunteer     |
| <input type="checkbox"/> EMT I | <input type="checkbox"/> EMS Supervisor | <input type="checkbox"/> Paid          |

**Vehicle Operator**

- |   |  |
|---|--|
| <input type="checkbox"/> EVOC/CEVO Trained (Year _____) |  |
| <input type="checkbox"/> Restrained                     | <input type="checkbox"/> Working Outside Environment           |
| <input type="checkbox"/> Unrestrained                   | <input type="checkbox"/> Working Inside Building (Non-vehicle) |

**Vehicle Occupant**

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Restrained   | <input type="checkbox"/> Working Outside Environment           |
| <input type="checkbox"/> Unrestrained | <input type="checkbox"/> Working Inside Building (Non-vehicle) |

**Mechanism of Injury**

- |  |   |
|--|---|
| <input type="checkbox"/> Animal Bite                 | <input type="checkbox"/> Fire                         |
| <input type="checkbox"/> Assault                     | <input type="checkbox"/> Hazardous Materials Exposure |
| <input type="checkbox"/> No Weapon                   | (Specify Product _____)                               |
| <input type="checkbox"/> With Weapon (Type _____)    | <input type="checkbox"/> Lifting/Bending              |
| <input type="checkbox"/> Carrying Equipment          | <input type="checkbox"/> Needle Stick                 |
| <input type="checkbox"/> Moving Patient              | <input type="checkbox"/> Pedestrian Struck            |
| <input type="checkbox"/> Transfer Onto/Off Stretcher | <input type="checkbox"/> Slip/Fall                    |
| <input type="checkbox"/> During Stretcher Transport  | <input type="checkbox"/> Structural Collapse          |
| <input type="checkbox"/> Electrical Injury           | <input type="checkbox"/> Toxic Inhalation             |
| <input type="checkbox"/> Explosion                   | <input type="checkbox"/> Other _____                  |

**Injury/Illness Description**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Respiratory    | <input type="checkbox"/> Death                | <input type="checkbox"/> Head Injury        | <input type="checkbox"/> Exposure        |
| <input type="checkbox"/> Cardiac        | <input type="checkbox"/> Fracture/Dislocation | <input type="checkbox"/> Spinal Injury      | <input type="checkbox"/> Heat            |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Laceration           | <input type="checkbox"/> Sprain/Strain      | <input type="checkbox"/> Cold            |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Burn                 | <input type="checkbox"/> Trauma Penetrating | <input type="checkbox"/> Exposure Hazmat |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Amputation           |   |  |

**Specify Body Part Affected**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Head                        | <input type="checkbox"/> Back   | <input type="checkbox"/> Leg ( <input type="checkbox"/> Left / <input type="checkbox"/> Right )  |
| <input type="checkbox"/> Neck                        | <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Hand ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Chest                       | <input type="checkbox"/> Arm ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) | <input type="checkbox"/> Foot ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Internal Organ/System _____ |   |  |

**Disposition: Admission**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Emergency Department Only  | <input type="checkbox"/> Critical Care Admission | <input type="checkbox"/> Personal Physician |   |
| <input type="checkbox"/> Hospital General Admission | <input type="checkbox"/> Deceased                | <input type="checkbox"/> None               | <input type="checkbox"/> Time Lost _____ (Days) |

*This page is intended to be used for documenting additional patients. Photocopy as necessary.*

**Patient #2 Information**

Age \_\_\_\_\_  Male  Female

Pre-event Condition  Stable  Unstable  Critical

Post Event Injury Condition  Stable  Unstable  Critical

**Injury/Illness Description**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Respiratory    | <input type="checkbox"/> Death                | <input type="checkbox"/> Head Injury          | <input type="checkbox"/> Exposure        |
| <input type="checkbox"/> Cardiac        | <input type="checkbox"/> Fracture/Dislocation | <input type="checkbox"/> Spinal Injury        | <input type="checkbox"/> Heat            |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Laceration           | <input type="checkbox"/> Sprain/Strain        | <input type="checkbox"/> Cold            |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Burn                 | <input type="checkbox"/> Trauma Penetrating   | <input type="checkbox"/> Exposure Hazmat |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Amputation           | <input type="checkbox"/> Possible Cause _____ |  |

**Specify Body Part Affected**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Head                        | <input type="checkbox"/> Back   | <input type="checkbox"/> Leg ( <input type="checkbox"/> Left / <input type="checkbox"/> Right )  |
| <input type="checkbox"/> Neck                        | <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Hand ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Chest                       | <input type="checkbox"/> Arm ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) | <input type="checkbox"/> Foot ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Internal Organ/System _____ |   |  |

**Disposition: Admission**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Emergency Department Only  | <input type="checkbox"/> Critical Care Admission | <input type="checkbox"/> Personal Physician |   |
| <input type="checkbox"/> Hospital General Admission | <input type="checkbox"/> Deceased                | <input type="checkbox"/> None               | <input type="checkbox"/> Time Lost _____ (Days) |

**Patient #3 Information**

Age \_\_\_\_\_  Male  Female

Pre-event Condition  Stable  Unstable  Critical

Post Event Injury Condition  Stable  Unstable  Critical

**Injury/Illness Description**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Respiratory    | <input type="checkbox"/> Death                | <input type="checkbox"/> Head Injury          | <input type="checkbox"/> Exposure        |
| <input type="checkbox"/> Cardiac        | <input type="checkbox"/> Fracture/Dislocation | <input type="checkbox"/> Spinal Injury        | <input type="checkbox"/> Heat            |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Laceration           | <input type="checkbox"/> Sprain/Strain        | <input type="checkbox"/> Cold            |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Burn                 | <input type="checkbox"/> Trauma Penetrating   | <input type="checkbox"/> Exposure Hazmat |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Amputation           | <input type="checkbox"/> Possible Cause _____ |  |

**Specify Body Part Affected**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Head                        | <input type="checkbox"/> Back   | <input type="checkbox"/> Leg ( <input type="checkbox"/> Left / <input type="checkbox"/> Right )  |
| <input type="checkbox"/> Neck                        | <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Hand ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Chest                       | <input type="checkbox"/> Arm ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) | <input type="checkbox"/> Foot ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Internal Organ/System _____ |   |  |

**Disposition: Admission**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Emergency Department Only  | <input type="checkbox"/> Critical Care Admission | <input type="checkbox"/> Personal Physician |   |
| <input type="checkbox"/> Hospital General Admission | <input type="checkbox"/> Deceased                | <input type="checkbox"/> None               | <input type="checkbox"/> Time Lost _____ (Days) |

*This page is intended to be used for documenting additional personnel or civilians. Photocopy as necessary.*

**Other Emergency Service Personnel or Civilian #2 Information**

Age \_\_\_\_\_  Male  Female

**Injury/Illness Description**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Respiratory    | <input type="checkbox"/> Death                | <input type="checkbox"/> Head Injury        | <input type="checkbox"/> Exposure        |
| <input type="checkbox"/> Cardiac        | <input type="checkbox"/> Fracture/Dislocation | <input type="checkbox"/> Spinal Injury      | <input type="checkbox"/> Heat            |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Laceration           | <input type="checkbox"/> Sprain/Strain      | <input type="checkbox"/> Cold            |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Burn                 | <input type="checkbox"/> Trauma Penetrating | <input type="checkbox"/> Exposure Hazmat |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Amputation           |   |  |

**Specify Body Part Affected**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Head                        | <input type="checkbox"/> Back   | <input type="checkbox"/> Leg ( <input type="checkbox"/> Left / <input type="checkbox"/> Right )  |
| <input type="checkbox"/> Neck                        | <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Hand ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Chest                       | <input type="checkbox"/> Arm ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) | <input type="checkbox"/> Foot ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Internal Organ/System _____ |   |  |

**Disposition: Admission**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Emergency Department Only  | <input type="checkbox"/> Critical Care Admission | <input type="checkbox"/> Personal Physician |   |
| <input type="checkbox"/> Hospital General Admission | <input type="checkbox"/> Deceased                | <input type="checkbox"/> None               | <input type="checkbox"/> Time Lost _____ (Days) |

**Other Emergency Service Personnel or Civilian #3 Information**

Age \_\_\_\_\_  Male  Female

**Injury/Illness Description**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Respiratory    | <input type="checkbox"/> Death                | <input type="checkbox"/> Head Injury        | <input type="checkbox"/> Exposure        |
| <input type="checkbox"/> Cardiac        | <input type="checkbox"/> Fracture/Dislocation | <input type="checkbox"/> Spinal Injury      | <input type="checkbox"/> Heat            |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Laceration           | <input type="checkbox"/> Sprain/Strain      | <input type="checkbox"/> Cold            |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Burn                 | <input type="checkbox"/> Trauma Penetrating | <input type="checkbox"/> Exposure Hazmat |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Amputation           |   |  |

**Specify Body Part Affected**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Head                        | <input type="checkbox"/> Back   | <input type="checkbox"/> Leg ( <input type="checkbox"/> Left / <input type="checkbox"/> Right )  |
| <input type="checkbox"/> Neck                        | <input type="checkbox"/> Abdomen  | <input type="checkbox"/> Hand ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Chest                       | <input type="checkbox"/> Arm ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) | <input type="checkbox"/> Foot ( <input type="checkbox"/> Left / <input type="checkbox"/> Right ) |
| <input type="checkbox"/> Internal Organ/System _____ |   |  |

**Disposition: Admission**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Emergency Department Only  | <input type="checkbox"/> Critical Care Admission | <input type="checkbox"/> Personal Physician |   |
| <input type="checkbox"/> Hospital General Admission | <input type="checkbox"/> Deceased                | <input type="checkbox"/> None               | <input type="checkbox"/> Time Lost _____ (Days) |

*This page is intended to be used for documenting additional vehicles involved. Photocopy as necessary.*

**Vehicle #3 Information**

**Type of Vehicle**

- Sedan
- SUV
- Pickup
- Truck (Semi)
- Truck (Straight)
- Other \_\_\_\_\_
- Other Emergency Vehicle \_\_\_\_\_

**Amount of Damage**

- Minor
- Moderate
- Severe
- Personal Injury
- Entrapment
- Airbag Deployment

**Vehicle #4 Information**

**Type of Vehicle**

- Sedan
- SUV
- Pickup
- Truck (Semi)
- Truck (Straight)
- Other \_\_\_\_\_
- Other Emergency Vehicle \_\_\_\_\_

**Amount of Damage**

- Minor
- Moderate
- Severe
- Personal Injury
- Entrapment
- Airbag Deployment

**Vehicle #5 Information**

**Type of Vehicle**

- Sedan
- SUV
- Pickup
- Truck (Semi)
- Truck (Straight)
- Other \_\_\_\_\_
- Other Emergency Vehicle \_\_\_\_\_

**Amount of Damage**

- Minor
- Moderate
- Severe
- Personal Injury
- Entrapment
- Airbag Deployment