



# Wintergreen Fire and Rescue

## Vehicle Incident Report

The following report should be completed by department personnel in the event that department owned property should be damaged in any way regardless of fault. The driver of the apparatus is responsible for completing this document if the damage occurs while in operation. If not, the senior crew member is responsible for the documentation. Report should be completed and forwarded to the Chief within 24 hours of the incident.

Date of Incident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Time of Incident: \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Unit Number: \_\_\_\_\_ Approximate MPH at the time of incident: \_\_\_\_\_

**Type of Incident: (circle)**

Single vehicle (vehicle vs. \_\_\_\_\_)

Multiple vehicles (# of vehicles \_\_\_\_\_)

Entrapment

Overtaken

**Status of Vehicle (Circle)**

Responding (emergency / non-emergency)

Transport (emergency / non-emergency)

Public Service

Other: \_\_\_\_\_

Weather conditions: \_\_\_\_\_

List any mechanical problems which may have been the proximate cause of the incident:

\_\_\_\_\_  
\_\_\_\_\_

Were seatbelts worn by all personnel on unit? If not, why not? \_\_\_\_\_

List the following information for any department personnel or ride-a-longs.

Driver: Name: \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

AIC / Officer: Name: \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Additional Personnel

Name: \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*(Continue on narrative page if additional space is needed)*

Document the following information on any injuries to crew members that resulted from this incident:

Name: \_\_\_\_\_ Type of injury: \_\_\_\_\_

Transported / Not Transported Required Treatment / No Treatment

Name: \_\_\_\_\_ Type of injury: \_\_\_\_\_

Transported / Not Transported Required Treatment / No Treatment

Name: \_\_\_\_\_ Type of injury: \_\_\_\_\_

Transported / Not Transported Required Treatment / No Treatment

*(Continue on narrative page if additional space is needed)*

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient's Initial Chief Complaint: \_\_\_\_\_ PPCR #: \_\_\_\_\_

List any complaints / injuries secondary to the incident: \_\_\_\_\_

\_\_\_\_\_

List any medical treatment required due to the incident: \_\_\_\_\_

\_\_\_\_\_

**Other Vehicle(s):**

Identify color, make, model, year, and tag # of any other vehicle(s) involved:

\_\_\_\_\_

Name of the other driver(s): \_\_\_\_\_

Name of passenger(s): \_\_\_\_\_

\_\_\_\_\_

Other vehicle(s) Insurance Company: \_\_\_\_\_

\_\_\_\_\_

List any injuries to driver / passengers of other vehicle(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Complete the following information on any witness(s) to the incident:

**(Each witness should fill out the witness statement form)**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Description of the events relating to the incident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What was the primary cause of the incident? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Draw a diagram of the scene placing your vehicle and other vehicles in the appropriate place. Feel free to use additional paper if needed.*

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

