



Please Note: This report is intended to be used by Emergency Service Organizations for internal use only. It is not an acceptable VFIS Claims form and therefore should not be submitted to VFIS.

Personal Injury/Illness Investigation Report

Emergency Service Organization _____ Date _____

Address _____

Name of Injured _____ Date of Birth _____

Address of Injured _____

Phone() _____ Age _____ Sex _____ Height _____ Weight _____

Occupation _____ Job Title _____

Social Security Number _____ Years with Dept. _____

Date of Injury _____ Time of Injury _____

Date Reported _____ Time Reported _____

Accident Reported To _____

Nature of Injury

- | | | |
|---|--|---|
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Multiple Injury | <input type="checkbox"/> Heat Exhaustion, Fatigue |
| <input type="checkbox"/> Inflammation | <input type="checkbox"/> Recurrence | <input type="checkbox"/> Abrasions, Contusions, Bruises |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Strain, Sprain, Torn Ligament | <input type="checkbox"/> Heart Malfunction |
| <input type="checkbox"/> Frostbite, Cold Exposure | <input type="checkbox"/> Cuts, Lacerations, Punctures | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Pinched Nerve, Ruptured Disk | <input type="checkbox"/> Inhalation, Fumes | <input type="checkbox"/> Burns |
| <input type="checkbox"/> Electric Shock | <input type="checkbox"/> Inhalation, Smoke | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical Injury | | |

Parts of Body Affected

- | | | |
|---|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Multiple Parts | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Knee(s) |
| <input type="checkbox"/> Head | <input type="checkbox"/> Back | <input type="checkbox"/> Ankle(s) |
| <input type="checkbox"/> Eye(s) | <input type="checkbox"/> Heart | <input type="checkbox"/> Foot/Feet |
| <input type="checkbox"/> Ear(s) | <input type="checkbox"/> Groin | <input type="checkbox"/> Ribs |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Arm | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Finger | |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Leg(s) | |

Where Injury Occurred

- | | | |
|---|--|--|
| <input type="checkbox"/> Station Maintenance | <input type="checkbox"/> Fundraising | <input type="checkbox"/> Standing By Station for Call |
| <input type="checkbox"/> Apparatus Maintenance | <input type="checkbox"/> Convention | <input type="checkbox"/> Training |
| <input type="checkbox"/> Emergency Scene | <input type="checkbox"/> Emergency Vehicle to Emergency | <input type="checkbox"/> Auxiliary Services |
| <input type="checkbox"/> Private Auto to Emergency | <input type="checkbox"/> Emergency Vehicle Non-Emergency | <input type="checkbox"/> Responding/Returning to Emergency (Non-Vehicle) |
| <input type="checkbox"/> Private Auto Non-Emergency | <input type="checkbox"/> Parades, Picnics, Contests | <input type="checkbox"/> Other _____ |

Cause of Injury

- | | | |
|---|--|---|
| <input type="checkbox"/> Fall | <input type="checkbox"/> Improper Lifting | <input type="checkbox"/> Inadequate Illumination |
| <input type="checkbox"/> Weather | <input type="checkbox"/> Horseplay | <input type="checkbox"/> Inadequate Ventilation |
| <input type="checkbox"/> Making Safety Devices Inoperative | <input type="checkbox"/> Structural Collapse | <input type="checkbox"/> Lack of Knowledge or Skill |
| <input type="checkbox"/> Using Defective Equipment | <input type="checkbox"/> Inadequate Guards or Protection | <input type="checkbox"/> Irrational Civilian |
| <input type="checkbox"/> Using Equipment Improperly | <input type="checkbox"/> Back Draft | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Failure to Use Personal Protection Equipment | <input type="checkbox"/> Improper Placement | <input type="checkbox"/> Abuse or Misuse |
| <input type="checkbox"/> Struck By Object | <input type="checkbox"/> Civil Disturbance | <input type="checkbox"/> Other _____ |

Injury Occurred - Performing What Task?

- | | | |
|--|--|--|
| <input type="checkbox"/> Forcible Entry | <input type="checkbox"/> Overhauling | <input type="checkbox"/> Rescue Operation |
| <input type="checkbox"/> Using Ladders | <input type="checkbox"/> Salvage | <input type="checkbox"/> Administering Medical Aid |
| <input type="checkbox"/> Advancing/Directing Hose Line | <input type="checkbox"/> Servicing/Repairing Equipment | <input type="checkbox"/> Physical Fitness |
| <input type="checkbox"/> Ventilating | <input type="checkbox"/> Extrication | <input type="checkbox"/> Other _____ |

Witness(es) to Injury: _____

Injured Person's Signature _____ Date _____

Investigation Report

Thoroughly describe accident: (What, How, Where, Equipment, Activity, etc.) _____

Hospitalized or Treated, Where? (Include Address) _____

Name and Address of Physician: (Include Referral) _____

Did the injury require individual to perform limited duties, or to be assigned to other duties or positions? YES or NO If yes, what duties or position? _____

And, what period of time? _____

Investigated by _____ Title _____ Date _____

Safety Officer's Report

What Acts, Failures to Act and/or Conditions Contributed Most Directly to This Accident? (Immediate Cause)

What Are the Basic or Fundamental Reasons for the Existence of These Acts and/or Conditions? (Fundamental Cause)

What Action Has or Will Be Taken to Prevent Recurrence? Place "X" By Items Completed.

Reviewed by Safety Officer _____ Title _____ Date _____