



VEHICLE COLLISION AND PERSONAL INJURY REPORT FORM

Send Original To:

MIEMSS
State Office of Commercial Ambulance
Licensing and Regulation
653 West Pratt, Suite 313
Phone: (410) 706-8511

This Report Must Be Filed Within 72 Hours of Incident.

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 the vehicle driver complete a standardized EVOC Course? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Service Info	Service Name:	License Number:	
	Name/Title of Person Completing Report:		
	Telephone:	E-mail:	Pager:
	Address:		
	City:	State:	Zip:

Veh. 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		

Accident Info	Number of Vehicles Involved:	Involved Collision With:
	EMS: Other Emergency Service: Civilian:	<input type="checkbox"/> Vehicle in Traffic <input type="checkbox"/> Parked Vehicle <input type="checkbox"/> Natural Object (tree etc) <input type="checkbox"/> Bicycle <input type="checkbox"/> Fixed Object (pole etc) <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other:
	Impact Type:	

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
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Traffic Controls: Stop Sign Yield Sign Signal Light Other Warning Sign/Signal

If at Traffic Signal-Signal Facing EMS Vehicle at Time of Incident: Red Yellow 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
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Warning Devices In Use:
 Visual (Red Lights) Audible (Siren) Headlights Only None

Mode of Service at Time of Incident:	
<input type="checkbox"/> Routine Driving	<input type="checkbox"/> Parked at Incident
<input type="checkbox"/> Responding to Non-emergency	<input type="checkbox"/> Parked-Other than at Incident
<input type="checkbox"/> Responding to Emergency	<input type="checkbox"/> Training
<input type="checkbox"/> Transporting Patient-Non-Emergency	<input type="checkbox"/> Backing
<input type="checkbox"/> Transporting Patient-Emergency	<input type="checkbox"/> Other:

Injury Info	Driver distracted? YES NO Reason: _____ _____ *Description of the Event: _____ _____ _____ *The Following Injury Reports must be completed for all EMS personnel and other injured in this vehicle.					
	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: _____		
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 Number: _____		
	If Police Report Was Filed and Copy Not Attached Complete the Following					
	Investigating Police Agency:			Investigating Officer:		
	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, 2=Front seat passenger, 3=Squad bench seated, 4= Captain's chair, 5= Litter, 6= Standing (pt. compartment)

***Use additional sheets as necessary.**