



Ross Township Fire District Accident/Analysis Form

Swift Policy #:
05906387

PARTICULARS OF ACCIDENT

Fire Department Number	Date/Time of Accident	Date/Time Reported
Location of Accident		Did Accident Occur on Employers Premise

PERSON INJURED INFORMATION

Name		Address	County
Date of Birth	Age	Phone Number	
SSN	Marital Status	Date of Hire/Start Date	
Type of Injury		Part of Body Affected	

THE ACCIDENT

Description of What Happened			
Analysis (What were the causes of the accident?)			

Were Safeguards and Safety Equipment provided/used?

Where vehicles involved? Yes No If Yes, Please list the following information:

Vehicle License Plate#/State

Operators Name

Operators License#

Insurance/Policy#

Where there any Witnesses to the Accident? Yes No If Yes, Please fill in the following information:

Witness Name

Witness Phone#

Initial Treatment (Please check one below)

No Medical Needed

Treated but No Clinical or Hospital Needed

Treated and transported to Clinical or Hospital (if checked provide information below):

Hospital Name/Address/Phone#

Hospitalized for more than 24hrs?

IF TREATMENT WAS PROVIDED

Type of treatment given	Name of person giving Treatment	Did Treatment Improve Patients Condition?

ACCIDENT INVESTIGATION

Accident Investigated by	Signature	Date
--------------------------	-----------	------

PREVENTION

What action has or will be taken to prevent a recurrence?

BY SIGNING BELOW YOU AGREE THAT THE INFORMATION PROVIDED IS TRUE AND ACCURATE

Signature of Volunteer

Date: