CECIL COUNTY GOVERNMENT
Risk Management
Volunteer Fire Report of Incident

This form must be completed for all on-duty Volunteer Incidents involving County Volunteer Fire Company Personnel.
SECTION 1 & 2 MUST BE COMPLETED AND FAXED TO RISK MANAGEMENT BY THE END OF THE WORKDAY IN WHICH THE INCIDENT OCCURS. FAX 1-888-517-8311

SECTION 1- Completed by Volunteer (or representative)

Name-Volunteer/Individual involved in incident

Date of Incident

Time of Incident hrs ☐ am ☐ pm ☐

Volunteer's Home Address-Street

City, State, Zip Code

Time Volunteer started working hrs ☐

Fire Company & Station Number

Injured Volunteer's Position

Phone Number ☐ **Work**

Name & Title of Officer Notified

Type of Incident

☐ **Volunteer**

☐ Probationary Member

Membership Date

Location of Incident (Be specific, include address)

Occurred (attach additional sheets if needed)

Circumstances of Incident (i.e. weather conditions, view obstructions, etc.)

What led to the Incident (i.e. unsafe conditions, equipment failure, unsafe act, etc.)

Date and Time Chief or Designee Notified of Incident

Injury Description-Be Specific (i.e. Right Ankle Sprain)

Witness #1 Name and Address (attach witness statement) ☐ **Cell /** ☐ **Work Phone** **Home Phone**

Witness #2 Name and Address (attach witness statement) ☐ **Cell /** ☐ **Work Phone** **Home Phone**

Volunteer Signature **Date**

Name-Volunteer/Individual: _____ **Date of Incident:** _____

SECTION 2 – Complete ONLY if Volunteer Injury or Illness Occurred

Medical Care Sought? Yes ☐ No ☐

Injury Description-Be Specific (i.e. Right Ankle Sprain)

Volunteer Currently Working? Yes ☐ No ☐

If No, Last Day and Hour Worked

Check all that Apply

☐ Returned to Duty as Volunteer on Date of Incident
☐ Physician's Office
☐ First Aid Treatment
☐ Emergency Room_____
☐ Hospitalized
☐ Transported by Ambulance
☐ Other-_____

Name of Hospital/Facility

Social Security Number

Date of Birth

Gender

Male ☐ Female ☐

Marital Status

Married ☐ Single ☐

Was Volunteer responding to a call at the time of the incident? Yes ☐ No ☐

Volunteer's Current Employer's Name, Address & Telephone Number

Complete and FAX Section 1 & 2 to Risk Management by the End of the Workday in which the Incident Occurs*

SECTION 3 – Completed by Fire Chief or Designee-FAX completed form within 3 Business Days

Review the Incident, Describe all Unsafe Conditions, Physical Hazards, and Unsafe Acts-Attach additional sheets if needed

Was the Incident The Result of an Unsafe Act? Yes ☐ No ☐ **The Result of an Unsafe Condition?** Yes ☐ No ☐

The Result of an or Unsafe Procedure? Yes ☐ No ☐ **Contributed to by a Physical Hazard?** Yes ☐ No ☐

Was the Incident Preventable? Yes ☐ No ☐ **Call # or Report #**

Was the incident training related? Yes ☐ No ☐

If Yes to Either above, or if other contributing factors are identified, Describe in detail-attach additional sheets if needed

Was the Volunteer trained on policies/procedures/safety rules relative to this incident? Yes ☐ No ☐

Will refresher training be initiated? Yes ☐ No ☐

If No, Describe-attach additional sheets if needed

Describe what Actions have been taken to Prevent Recurrence of this type of Incident-attach additional sheets if needed

Chief or Designee (Print Name & Position)

Fire Company & Station Number

Chief or Designee Signature

Phone Number

Date

Chief's Signature

Chief's Name Print

Date Chief

Chief Phone Number (if not provided above)

Phone 410-996-8477

Please FAX to:

FAX 1-888-517-8311

Cecil County Government, Department of Human Resources
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