ORLEANS COUNTY SELF INSURANCE PLAN
Incident & Accident Report

PLEASE TYPE

Department ____________ Date of Incident ____________ Time ________ ☐ AM ☐ PM

Person Involved ____________ ____________ ______ ____________
Last Name / First Name / M.I. / Date of Birth

____________ ____________ ______ ______ ____________
Street Address / City / State / Zip / Phone

☐ employee
☐ volunteer firefighter
☐ client
☐ ____________
☐ ____________

☐ first aid (describe) ____________
☐ by whom ____________
☐ physician called (name) ____________
☐ hospital (where) ____________
☐ police notified (name) ____________
☐ fire dept. called (name) ____________
☐ insurance carrier notified ____________

DESCRIBE:
Exact Location ____________

Reason for Presence ____________

Property Involved ____________

Equipment Involved ____________

Exactly What Happened ____________

Witnesses Name	Address	Phone

Date of Report ________ Time ________ ☐ AM ☐ PM ____________
Signature of Preparer

SUPERVISION FOLLOW-UP

If employee: or volunteer firefighter
- was safety training given prior to incident? ☐ Yes ☐ No Date ________ By ________
- were safety rules violated? ☐ Yes ☐ No Which? ________
- were back support belts required? ☐ Yes ☐ No
- were they being used? ☐ Yes ☐ No N/A
- if injured, has Workmens Compensation form C-2 F been completed? ☐ Yes ☐ No

Remedial action to be taken ____________

Signature of supervisor ____________ Title ____________ Date ________
Appointing Authority or Fire Chief signature: ____________ Title ____________ Date ________

Copies: ☐ Plan Administrator ☐ Safety Officer ☐ Appointing Authority / Fire Chief ☐ Preparer