Submit by Email Print Form

**CAROLINE COUNTY**
**FIRE – RESCUE**
**PRELIMINARY INSURANCE INCIDENT REPORT**

**TYPE OF INCIDENT: (CHECK ONE)**

☐ **INJURY** ☐ **VEHICLE ACCIDENT** ☐ **EQUIPMENT DAMAGE/LOSS**

Each person injured must complete an incident report and Hartford Insurance forms.

Date and approximate time that incident/accident occurred resulting in a claim being filed.

Date: _____ Time: _____

Name of Person filing report: _____

Social Security #: _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Station Assignment: Career _____

Officer in Charge of Incident:

Name: _____Station: Career _____Unit #: _____

If multiple personnel involved, please complete the additional personnel form (Attachment A) for each one as a witness or injured party in the same incident.

Location of Incident/Accident: _____

Summary of events that led to insurance claim being filed:

_____

_____

_____

_____

Type of activity being conducted when injury/accident occurred:

_____

_____

_____

Weather Conditions: _____

**Please complete this section if claim is being filed for personal injury:**

Type of injury: _____

Type of Medical Action Taken:

_____

_____

_____

(If transported to medical facility, please list name and address of receiving facility) _____

Was a Hartford Insurance form taken with the patient to the treatment facility or faxed by Communications? Yes ____ No ____

**Please complete this section if vehicle involved: ****

Make: _____ Model: _____

Year: _____ VIN #: _____

Description of Damage:

_____

_____

_____

****** ***Please forward estimates or bills for repairs to Fire Administration***.

**Please complete this section for damaged / lost equipment: ****

**Damaged:**

Type of equipment: _____

Model #: _____

Description of damage: _____

**Lost:**

Type of equipment: _____

Model #: _____

Description of damage: _____

**** Please forward estimates or bills for repairs to Fire Administration.**

**ADDITIONAL INFORMATION TO BE COMPLETED BY OTHER PERSONNEL INVOLVED AS A WITNESS OR INJURED PARTY IN THE INCIDENT.**

Name: _____

Address: _____

Age: _____ D.O.B. _____ SSN: _____

Home Phone: _____ Work Phone: _____

Name: _____

Address: _____

Age: _____ D.O.B. _____ SSN: _____

Home Phone: _____ Work Phone: _____

Name: _____

Address: _____

Age: _____ D.O.B. _____ SSN: _____

Home Phone: _____ Work Phone: _____

**ADDITIONAL INFORMATION CAN BE ATTACHED ON A SEPARATE PIECE OF PAPER.**

**PRELIMINARY INSURANCE INFORMATION FORM**
**(ATTACHMENT A)**

Date and approximate time that incident/accident occurred resulting in claim being filed.

Date: _____ Time: _____

Name: _____

Address: _____

_____

Social Security #: _____ DOB: _____

Home Phone: _____ Work Phone: _____