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|  |   |  | **INCIDENT REPORT** |  |  |  |  |  |
| **NAME OF OFFICER**  | **SUPERVISOR ON DUTY** | **OTHER OFFICER(S) ON DUTY** |
| **CLASSIFICATION OF INCIDENT: PERSONAL INJURY\_\_\_\_ FIRE ALARM PROPERTY DAMAGE BURGLARY VANDALISM .** **ASSAULT DISTURBANCE UNSECURE AREA MVA TRESPASSIING LARCENY\_\_\_\_\_ OTHER\_\_\_\_**  |
| **DATE OF INCIDENT** | **TIME** | LOCATION | **APT.** |
| **DATE INCIDENT REPORTED** | **TIME** | **HOW WAS INCIDENT REPORTED-PHONE, RADIO, Etc.?** |
| **NAME OF PERSON WHO REPORTED INDCIDENT** | **ADDRESS** | **APT.** | **PHONE** |
| **INFORMATION REGARDING PERSONS INVOLVED** | CLASSIFICATION: VICTIM #1, WITNESS #2, SUSPECT #3, DRIVER #4, COMPLAINANT #5, OTHER #6.  |
| **Name** | **PHONE** | **D.O.B. AGE** | **SEX** | **RACE** | **ADDRESS, DESCRIPTION, AND /OR S.S. #** | **CLASS** |
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| **VEHICLE INVOLVED: CLASSIFICATION: MVA #1, STOLEN #2, VANDALIZED #3, EQUIPMENT STOLEN #4, FIRE #5, OTHER #6** |
| **REG./STATE** | **YEAR** | **MAKE** | **COLOR** | **OWNER** | **ADDRESS** | **PHONE** | **CLASS** |
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| **POLICE NOTIFIED: YES \_\_\_\_ NO \_\_\_\_\_ NAME/BADGE #**  |
| **FIRE DEPTARTMENT and/or EMS NOTIFIED: YES \_\_\_\_ NO \_\_\_\_\_** **AMBULANCE SERVICE RESPONDING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DATE TIME** |
| **SECURITY SUPERVISOR NOTIFIED: YES \_\_\_\_\_ NO \_\_\_\_\_\_ NAME:**  |  |  |
| **PROPERTY MGR. NOTIFIED: YES \_\_\_\_\_ NO \_\_\_\_\_\_ NAME:**  |  |  |
| **OTHER PERSON(S) NOTIFIED: YES \_\_\_\_\_ NO \_\_\_\_\_\_ NAME:**  |  |  |
| **NARRATIVE OF INCIDENT (continue on additional pages if necessary):** |
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| **SIGNATURE OF PERSON REPORTING** | **DATE** | **TIME** | **SIGNATURE OF SUPERVISOR** | **DATE** | **TIME** |

**MEDICAL REPORT/WAIVER**

**PATIENT INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_ (AM/PM)

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location Found: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street) (City) (State) (Zip)

Age: \_\_\_\_\_\_ Ambulance Required? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

**CHIEF COMPLAINT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PATIENT’S VITAL SIGNS:** Pulse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ B/P: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temp: \_\_\_\_\_\_\_\_\_\_\_\_ Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Respiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S MEDICAL HISTORY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**KNOWN ALLERGIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARE GIVEN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**OTHER REMARKS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SIGNATURES OF RESPONDING EMT’S/WITNESS’S:\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

**REFUSAL OF TREATMENT BY THE PATIENT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am at least 18 years old and of sound mind. I do not wish to be treated

for my injuries/illness, or be assisted in anyway. I have been instructed to seek medical attention, but I do not wish to be assisted at this time, I am releasing Three Rivers Community College and the EMT’s available from any liability that my result.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

 Patient’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

 Witness (Staff)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

 Witness