



## **EMS Information Bulletin- #13**

**DATE:** April 12, 2004

**SUBJECT:** Revised EMS Vehicle Collision and/or Injury Report Form

**TO:** Ambulance Services

**FROM:** Emergency Medical Services Office  
PA Department of Health  
(717) 787-8740

Attached is a copy of the revised EMS Vehicle Collision and Injury Report Form, dated March 24, 2004. Instructions for completing the form are also attached.

The EMS regulations, §1005.10(e)(i) requires ambulance services to report, in a form or manner prescribed by the Department, to the appropriate regional EMS council an ambulance vehicle accident that is reportable under 75 Pa.C.S., and an accident or injury to an individual that occurs in the line of duty of the ambulance service that results in a fatality, or medical treatment at a medical treatment facility. This revised form has been adopted by the Pennsylvania Department of Health, EMS Office to meet the requirements of the regulations. The form will be placed on the Department of Health website for use by ambulance services.

Please contact Mr. Robert H. Gaumer at (717) 787-8740 or through e-mail at [rgaumer@state.pa.us](mailto:rgaumer@state.pa.us) if you have any questions.

[Attachments \(Click here to download form\)](#)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <br><b>DEPARTMENT OF HEALTH</b><br>...in pursuit of good health<br><b>EMS VEHICLE COLLISION<br/>AND/OR<br/>PERSONAL INJURY REPORT FORM</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                      | Send Original To Regional EMS Council                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b><i>This Report Must Be Filed Within 24 Hours of Incident and Within 8 Hours If Fatality Involved.</i></b>                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| Date Of Accident / Injury<br>Mo      Day      Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                      | Day of the Week<br>M T W Th F Sa Su<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                      | Hour-<br>Military Time                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                      | Did Vehicle Driver Complete an EMSO Approved EVOC Course<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| I. Service Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Service Name:                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                       | Affiliate Number:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Name/Title of Person Completing Report:                                                                                                                                                                                                                              |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Telephone:                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                       | Email:                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Address:                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | City:                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                       | State:      Zip:                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>IF COMPLETING PERSONNEL INJURY REPORT ONLY PROCEED TO SECTION V</b>                                                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| II. Vehicle Info.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | EMSO Vehicle Decal Number:                                                                                                                                                                                                                                           |                                                                                                                                                                                                                       | Vehicle Drivable after Accident:<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Approximate Damage Amount: <input type="checkbox"/> \$0-\$1,000 <input type="checkbox"/> \$1,000-\$5,000 <input type="checkbox"/> \$5,000-\$10,000<br><input type="checkbox"/> \$10,000-\$25,000 <input type="checkbox"/> >\$25,000                                  |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| III. Motor Vehicle Accident Incident Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Number of Vehicles Involved:<br>EMS:<br>Other Emergency Service:<br>Civilian:                                                                                                                                                                                        |                                                                                                                                                                                                                       | Involved Collision With:<br><br><input type="checkbox"/> Animal <input type="checkbox"/> Vehicle in Traffic<br><input type="checkbox"/> Natural Object (tree etc) <input type="checkbox"/> Overturned in Road<br><input type="checkbox"/> Fixed Object (pole etc) <input type="checkbox"/> Parked Vehicle<br><input type="checkbox"/> Pedestrian <input type="checkbox"/> Left Road-No Impact<br><input type="checkbox"/> Bicycle <input type="checkbox"/> Other: |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Impact Type:<br><input type="checkbox"/> Front to Rear <input type="checkbox"/> Side Impact<br><input type="checkbox"/> Sideswipe <input type="checkbox"/> Head-On<br><input type="checkbox"/> Rollover <input type="checkbox"/> Other                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Street Name or Route Number where Accident Occurred:                                                                                                                                                                                                                 |                                                                                                                                                                                                                       | MCD Code Where Accident Occurred:                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Nearest Intersection or Mile Marker:                                                                                                                                                                                                                                 |                                                                                                                                                                                                                       | Number of Lanes:                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Did Incident Occur at Intersection:<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                      |                                                                                                                                                                                                                       | Approximate Speed Prior to Incident:<br><input type="checkbox"/> 0-10 <input type="checkbox"/> 10-25 <input type="checkbox"/> 25-35 <input type="checkbox"/> 35-45<br><input type="checkbox"/> 45-55 <input type="checkbox"/> 55-65 <input type="checkbox"/> >65                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Traffic Controls: <input type="checkbox"/> Stop Sign <input type="checkbox"/> Yield Sign <input type="checkbox"/> Signal Light <input type="checkbox"/> Other Warning Sign/Signal<br><input type="checkbox"/> Traffic pre-emption device (Opticom or EMS controlled) |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | If at Traffic Signal-Signal Facing EMS Vehicle at Time of Incident: <input type="checkbox"/> Red <input type="checkbox"/> Yellow <input type="checkbox"/> Green                                                                                                      |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Weather:<br><input type="checkbox"/> Clear <input type="checkbox"/> Foggy <input type="checkbox"/> Cloudy<br><input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> Ice                                                                |                                                                                                                                                                                                                       | Light Conditions:<br><input type="checkbox"/> Daylight <input type="checkbox"/> Dark-Road Lighted<br><input type="checkbox"/> Dusk/Dawn <input type="checkbox"/> Dark-Road Unlighted                                                                                                                                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Road Surface:<br><input type="checkbox"/> Dry <input type="checkbox"/> Wet<br><input type="checkbox"/> Icy <input type="checkbox"/> Snow                                                                                                                             |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Warning Devices In Use:<br><input type="checkbox"/> Visual (Red Lights) <input type="checkbox"/> Audible (Siren) <input type="checkbox"/> Headlights Only <input type="checkbox"/> None                                                                              |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| Mode of Service at Time of Incident:<br><input type="checkbox"/> Responding to Emergency <input type="checkbox"/> Transporting Patient-Emergency<br><input type="checkbox"/> Responding to Non-emergency <input type="checkbox"/> Transporting Patient-Non-Emergency<br><input type="checkbox"/> Parked at Incident <input type="checkbox"/> Parked-Other than at Incident<br><input type="checkbox"/> Routine Driving <input type="checkbox"/> Backing<br><input type="checkbox"/> Training <input type="checkbox"/> Other |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |

|                                      |                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| <b>IV-Description</b>                | <b>Description of the Event:</b><br><div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px;"></div> |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|                                      | <i>The following injury reports must be completed for all EMS personnel and others injured.</i>                                                                                                                                                                                   |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
| <b>V. Injury Information</b>         | <b>Injury A</b><br>EMS: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                  |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|                                      | Age                                                                                                                                                                                                                                                                               | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Injury Severity:<br><input type="checkbox"/> Fatal<br><input type="checkbox"/> Serious<br><input type="checkbox"/> Moderate<br><input type="checkbox"/> Minor | Injury Related To:<br><input type="checkbox"/> MVA<br><input type="checkbox"/> Fall<br><input type="checkbox"/> Needle stick<br><input type="checkbox"/> Lifting Patient<br><input type="checkbox"/> Ordinary Lifting | <input type="checkbox"/> Pedestrian Struck<br><input type="checkbox"/> Body Fluid Exp.<br><input type="checkbox"/> Hazardous Mat.<br><input type="checkbox"/> Assault<br><input type="checkbox"/> Other | Ejected<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No | *Position in Vehicle if MVA:<br>Enter #<br><div style="border-bottom: 1px solid black; width: 50px; margin-top: 5px;"></div> |
|                                      | <b>Injury B</b><br>EMS: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                  |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|                                      | Age                                                                                                                                                                                                                                                                               | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Injury Severity:<br><input type="checkbox"/> Fatal<br><input type="checkbox"/> Serious<br><input type="checkbox"/> Moderate<br><input type="checkbox"/> Minor | Injury Related To:<br><input type="checkbox"/> MVA<br><input type="checkbox"/> Fall<br><input type="checkbox"/> Needle stick<br><input type="checkbox"/> Patient Lifting<br><input type="checkbox"/> Ordinary Lifting | <input type="checkbox"/> Pedestrian Struck<br><input type="checkbox"/> Body Fluid Exp.<br><input type="checkbox"/> Hazardous Mat.<br><input type="checkbox"/> Assault<br><input type="checkbox"/> Other | Ejected<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No | *Position in Vehicle if MVA:<br>Enter #<br><div style="border-bottom: 1px solid black; width: 50px; margin-top: 5px;"></div> |
|                                      | <b>Injury C</b><br>EMS: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                  |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|                                      | Age                                                                                                                                                                                                                                                                               | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Injury Severity:<br><input type="checkbox"/> Fatal<br><input type="checkbox"/> Serious<br><input type="checkbox"/> Moderate<br><input type="checkbox"/> Minor | Injury Related To:<br><input type="checkbox"/> MVA<br><input type="checkbox"/> Fall<br><input type="checkbox"/> Needle stick<br><input type="checkbox"/> Patient Lifting<br><input type="checkbox"/> Ordinary Lifting | <input type="checkbox"/> Pedestrian Struck<br><input type="checkbox"/> Body Fluid Exp.<br><input type="checkbox"/> Hazardous Mat.<br><input type="checkbox"/> Assault<br><input type="checkbox"/> Other | Ejected<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No | *Position in Vehicle if MVA:<br>Enter #<br><div style="border-bottom: 1px solid black; width: 50px; margin-top: 5px;"></div> |
| <b>Vi. Police Report Information</b> | Did Police Investigate This Incident: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                    |                                                                 |                                                                                                                                                               | Police Report Attached:<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                   |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|                                      | <b>If Police Report Was Filed and Copy Not Attached, Complete the Following:</b>                                                                                                                                                                                                  |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|                                      | Investigating Police Agency:                                                                                                                                                                                                                                                      |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|                                      | Address:                                                                                                                                                                                                                                                                          |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|                                      | City:                                                                                                                                                                                                                                                                             |                                                                 | State:                                                                                                                                                        |                                                                                                                                                                                                                       | Zip:                                                                                                                                                                                                    |                                                                        |                                                                                                                              |
|                                      | Citations Issued:<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                     |                                                                 |                                                                                                                                                               | Issued To:<br><input type="checkbox"/> EMS Driver <input type="checkbox"/> Other Driver                                                                                                                               |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
| <b>Vii. Sign</b>                     | I believe the information provided above to be accurate and correct:                                                                                                                                                                                                              |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |
|                                      | Sign: _____ Title: _____ Date: _____                                                                                                                                                                                                                                              |                                                                 |                                                                                                                                                               |                                                                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                        |                                                                                                                              |

**\*Vehicle Position Identification Information:**

- |                                |                                  |          |
|--------------------------------|----------------------------------|----------|
| 1=Driver's seat                | 6=Captain's chair                | 11=Other |
| 2=Front seat passenger         | 7=Squad bench/seat               |          |
| 3=Squad bench seated           | 8=Driver's side                  |          |
| 4=Squad bench supine (patient) | 9=Litter                         |          |
| 5=Backseat, squad unit         | 10=Standing, patient compartment |          |

Use additional sheets as necessary if more than three injured individuals.

# **Instructions for Completion of the EMS Vehicle Collision And/or Personnel Injury Report Form**

## **General Information:**

**Date of Accident/Injury:** Please enter the month, day and year in this block, e.g., (mm/dd/yyyy)

**Day of the week:** Indicate the appropriate box for the day of the week that the accident/injury occurred.

**Hour:** Enter in military time the time that the accident/injury occurred e.g., 0900, 1300, 1830, 1945, etc.

**Did the Vehicle Driver Complete an EMSO Approved EVOC Course:** indicate yes or no in the corresponding box.

## **Section I-Service Information:**

**Service Name:** Enter the name of the ambulance service.

**Affiliate Number:** Enter the 5-digit affiliate number assigned to the ambulance service.

**Name/Title of Person Completing Report:** Enter the name of individual who is completing this report.

**Telephone Number:** E-Mail Address/ Pager Number: Enter the appropriate information.

**Address:** enter the complete address information for the ambulance service.

**NOTE: If completing personnel injury report only proceed to section V.**

## **Section II-Vehicle Information:**

**EMSO Vehicle Decal Number:** Enter the seven-digit number from the licensure decal of the vehicle involved in the accident.

**Vehicle Drivable After Accident:** Indicate the appropriate box.

**VIN #:** Enter the vehicle identification number of the vehicle involved in the accident as found on the vehicles owners card or the vehicle.

**Approximate Damage Amount:** Indicate the appropriate box, which corresponds to the approximate damage amount in dollars due to the accident.

**Section III-Motor Vehicle Accident Information:**

**Number of Vehicles Involved:** Enter the number of vehicles to include emergency services and others involved in the accident.

**Involved Collision With:** Indicate the appropriate box that the vehicle was involved in the collision with.

**Impact Type:** Indicate the appropriate box as to the type of impact occurred by the vehicle.

**Street Name or Route Number Where Accident Occurred:** Enter the exact street or road location where the accident occurred.

**MCD Code Where Accident Occurred:** Enter the five-digit Minor Civil Division where the accident occurred, e.g., 48934 (Walnutport Borough in Northampton County).

**Nearest Intersection or Mile Marker:** Enter the nearest road intersection or the corresponding road mile marker where the accident occurred.

**Number of Lanes:** Enter the number of lanes on the street/road where the accident occurred.

**Did Accident Occur at Intersection:** Indicate the appropriate box.

**Approximate Speed Prior to Accident:** Indicate the appropriate box for the speed of the vehicle prior to the accident.

**Traffic Controls:** Indicate the appropriate box for the traffic controls that were in operation at the time of the accident.

**Traffic Signal:** Indicate the color of the traffic signal facing the vehicle at time of the accident.

**Weather:** Indicate the appropriate weather condition at the time of the accident.

**Light Conditions:** Indicate the appropriate light conditions at the time of the accident.

**Road Surface:** Indicate the appropriate road surface at the time of the accident.

**Warning Devices In Use:** Indicate the warning device(s) in use on the vehicle at time of the accident.

**Mode of Service at Time of Accident:** Indicate the mode in which the vehicle was responding prior to the accident.

#### **Section IV-Description of the Event**

Provide a detailed description of the events regarding the accident and how it occurred. (Use additional sheets if necessary).

#### **Section V-Injury Information**

The following information must be provided for any individual injured as a result of the accident or was injured by another means not related to an EMS vehicle collision:

- Check whether the injured person was a member of the EMS crew.
- Enter the age of the injured person.
- Check the severity of the injury.
- Check the appropriate box related to how the injury occurred.
- If an EMS vehicle collision, indicate if the injured person was ejected from a vehicle.
- From the list at the bottom of the form, indicate the position of the injured person in the ambulance and enter the appropriate number on the line provided.

Provide this same information for additional individuals on the form. Use additional sheets, if there are more than 3 injured personnel.

#### **Section VI-Police Report Information**

**Did Police Investigate This Incident:** Check the appropriate box.

**Police Report Attached:** Check the appropriate box.

**Police Report Filed but not Attached:**

- Enter the name of the investigating police agency.
- Enter the address, city, state and zip code of the police agency.
- Indicate whether a citation was issued.
- To whom the citation was issued.

#### **Section VII-Sign**

The individual will sign the form; enter his/her title and the date that the form was signed.

For assistance contact your regional EMS council or the Pennsylvania Department of Health at **[www.health.state.pa.us](http://www.health.state.pa.us)**