ACCIDENT AND INCIDENT REPORTING POLICY

HAZLET FIRE DISTRICT NO. 1

Of Hazlet Township, NJ

Sponsored by

Hazlet Township Board of Fire Commissioners

Fire District No. 1

Of Hazlet Township, NJ

Hazlet Fire Company #1
North Centerville Fire Company
West Keansburg Fire Company
The Bureau of Fire Prevention

PURPOSE

The purpose of this document is to define and establish Accident and Incident reporting policy for Hazlet Township Fire Department and its members.

SCOPE

All active firefighters and fire police members of this Fire District. Any employee of Hazlet Fire District #1.

POLICY

This policy at is adoption recognizes and adopts the Accident and Incident reporting procedures as set forth by Hazlet Fire Company #1, North Centerville Fire Company, and West Keansburg Fire Company.
Hazlet Township Board of Fire Commissioners requires all incidents and/or accidents, vehicle, apparatus, structural, and/or personal be documented and filed with the Fire District office and personal/vehicle files.

REQUIREMENTS

- Report accident to police department as needed
- Seek Medical attention as necessary
- Notify Chief and/or Line Officer on Duty
- Notify a Commissioner of The Board of Fire Commissioners
- Post-accident substance testing as per Hazlet Board of Fire Commissioners Substance Policy
- Report to insurance and/or contact district office/liaison to report to insurance
- File vehicle incident/accident report provided by The Board of Fire Commissioners
- File personal injury report provided by The Board of Fire Commissioners

DISCIPLINARY ACTION

The Hazlet Township Board of Fire Commissioners recognizes the disciplinary policy as set forth by Hazlet Fire Company #1, North Centerville Fire Company, and West Keansburg Fire Company regarding accident/incident reporting.
The Board of Fire Commissioners will implement disciplinary action for failure to comply with this policy if and/or when deemed necessary.

Disciplinary Action – Failure to Comply

- Verbal Warning
- Written Warning
- Failure to comply with this policy shall be considered a breach of contract and may lead to withholding of contractual monetary payments for The Board of Fire Commissioners.

DOCUMENTS REQUIRED IN VEHICLE/APPARATUS

- Vehicle accident/loss report
- Personal injury/illness report
- Consent for Substance Testing
- VFIS claim form and physician statement

HAZLET TOWNSHIP FIRE DISTRICT #1

Hazlet Fire Company #1
North Centerville Fire Company
West Keansburg Fire Company

Vehicle Accident/Loss Report

Fire Department____

Name of Driver____

List all Members in apparatus/vehicle_________________________________
____
____

Vehicle ______________ , ______________ Vehicle Vin #________________________________

Date of Accident________________ Time of Accident______________

Location of Accident____

Roadway

- ☐ Straight
- ☐ Curve
- ☐ On grade
- ☐ Level
- ☐ Dry
- ☐ Wet
- ☐ Muddy
- ☐ Snowy
- ☐ Icy
- ☐ Oily
- ☐ 2-lane
- ☐ 3-lane
- ☐ 4-lane
- ☐ Divided
- ☐ Lanes marked
- ☐ Road defects
- ☐ Holes, ruts
- ☐ Other_____

Weather

- ☐ Other vehicle/s__________________
- ☐ Other Person__________________
- ☐ Building/Structure_______________

Accident Occurred

- ☐ At Station
- ☐ Responding to Emergency
- ☐ At emergency scene
- ☐ Training
- ☐ Parade
- ☐ Other___________

Type of Loss

- ☐ Personal Injury
- ☐ Property Damage
- ☐ Vehicle Damage

Weather

- ☐ Clear
- ☐ Rain
- ☐ Snow
- ☐ Fog
- ☐ Sleet
- ☐ Sunny
- ☐ Other______

Description of Incident

Include cause if any, streets and cross streets, and other vehicles or persons involved.

____

____

____

____

____

____

____

Chief's/Officer on Duty Comments/Report

____

____

____

____

Driver's Signature____Date_______________________

Chief's/Officer of Duty Signature_____________________________Date_______________________

HAZLET TOWNSHIP FIRE DISTRICT #1

Hazlet Fire Company #1
North Centerville Fire Company
West Keansburg Fire Company

Personal Injury/Illness Report

Fire Company Information

Name_____________________________ Address_________________________________
Chief_____________________________ Phone Number___________________________

Injured Member Information

Name_______________________________ Address____

Date of Birth________ Age_____ Gender_____ Member's Title_____________________________

Date of Injury________________ Time of Injury___________ Location of Injury__________________

Date Reported_______________ Time Reported_______________ Person Reported to_____________

Nature of Injury

☐ Burns ☐ Smoke Inhalation ☐ Fumes Inhalation ☐ Eye Injury

☐ Chemical Exposure ☐ Blood/Body Fluids Exposure ☐ Heat Exhaustion ☐ Other_______

Parts of Body Affected

☐ Head ☐ Eye(s) ☐ Ear(s) ☐ Neck

☐ Shoulder ☐ Chest ☐ Abdomen ☐ Back

☐ Groin ☐ Arm ☐ left ☐ right ☐ Hand ☐ left ☐ right ☐ Ribs

☐ Leg ☐ left ☐ right ☐ Hip ☐ left ☐ right ☐ Foot ☐ left ☐ right

☐ Ankle ☐ left ☐ right ☐ knee ☐ left ☐ right ☐ finger(s)__________________

Where Injury Occurred

☐ Emergency Scene ☐ Apparatus Maintenance ☐ Station Maintenance ☐ Station

☐ Training ☐ Drill ☐ Emergency Vehicle

☐ Chief sanction event- (parade, event coverage, fund raiser, etc.) ☐ Other __________________

Cause of Injury

☐ Fall ☐ Struck by Object ☐ Weather ☐ Lifting

☐ Structural Collapse ☐ Back Draft ☐ Defective Equipment ☐ Other_____

☐ During motor vehicle accident

Investigation Report

Describe Accident in detail (What, How, Where, Equipment, Activity, etc.)

____

____

____

____

____

Hospitalized or Treated Where, When, date- list hospital or physician, address.

____

____

Did injury cause loss of work? ☐ Yes ☐ No Period of time out of work ____________________

Was their a Witness to the incident ☐ Yes ☐ No If yes member name ____________________

Chief's Report/Comments

____

____

____

____

Witness Statement if applicable ____

____

____

Injured Member Signature ____ Date ____________

Witness Signature ____ Date ____________

Chief's Signature ____ Date ____________

ATTENDING PHYSICIAN'S STATEMENT

Please Complete and Mail To:

VFIS
P.O. Box 5126, York, Pennsylvania 17405-9726
Call (717) 741-0911 · Toll Free: (800) 233-1957
Fax # (717) 747-7051

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

NOTE: SEE ENCLOSED SHEET FOR IMPORTANT STATE INFORMATION.

Name of Patient ______________________________ DOB ________

Address ______________________________ Telephone ______________

Regular Occupation ______________________________

Name of Insured Organization Hazlet Twp.BOFC District #1 Policy No. VFP4431-2229E-06

IMPORTANT

Have Insured Member (Patient) sign following Authorization

I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish to VFIS, Inc., any and all information with respect to any accident or illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature ______________________________
Insured Member Patient

PART B – TO BE COMPLETED BY ATTENDING PHYSICIAN

The above named individual has filed a claim for benefits as a result of the Injury/Illness for which he/she is currently or has been under your care. In order that we might give his claim proper attention, would you kindly answer the following questions at your earliest convenience and forward completed form to us.

(1) Diagnosis and concurrent conditions (If fracture or dislocation, describe nature and location, If Sickness / Illness describe nature).

(2A) When did symptoms first appear or accident happen? Date ________

(B) When did patient consult you for this condition? Date ________

(C) Has patient ever had same or similar condition? (If Yes, state when and describe) ☐ Yes ☐ No

(3A) Nature of surgical procedure, If Any (Describe Fully) - Date Performed ________ ☐ Inpatient ☐ Outpatient

(B) If performed in hospital, give name and address:

(4) What other services, if any, did you provide patient?

(5) Is patient still under your care for this condition? ☐ Yes ☐ No
If "No" give date your services terminated. ________ Date ________

(6A) How long was or will patient be continuously totally disabled due to diagnosis in #1 above?
(Unable to perform Regular Occupation) From Date ________ Through ________

(B) How long was or will patient be partially disabled? From Date ________ Through ________

(C) Approximate date patient will return to work if still disabled Date ________

(7) Restrictions:

Date ________ Signature ______________________________
(attending physician) (degree) (telephone no.)

Address ______________________________

Fraud Warning

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicable in Arizona

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Applicable in California

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Applicable in Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in New York

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Pennsylvania

WARNING: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.

Applicable in Rhode Island

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in West Virginia

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in All Other States

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.