CARROLL COUNTY
Department of Fire & EMS

FIRE DEPARTMENT INCIDENT INSURANCE INFORMATION FORM

This form should be utilized to provide insurance claim notification for incidents involving personal injury (non-member) at fire department facility events and property claims due to weather or personal property loss of members.

Reporting: ❑ **Personal Injury (non-member)** ❑ **Property**

Personal Injury (Non-Member):

Name (Last, First, M.I.):	DOB:		Cell Phone #:	
Home Address:	County/State/Zip Code:		Gender: ❑ M ❑ F	
Email Address:	Department:	Incident #:	Date Injury Reported?	Time Injury Reported?
# Of Civilian Injuries:	# Of Civilians Transported:		Transported to Hospital: ❑ Yes ❑ No	
Accident Location:		Accident County:	Accident Date:	Accident Time:
Supervisor Name:	Supervisor Phone #:	Supervisor Title:		
Safeguards Provided? ❑ Yes ❑ No	Safeguards Used? ❑ Yes ❑ No	Accident On Premises? ❑ Yes ❑ No	Unsafe Act Committed? ❑ Yes ❑ No	Reason to Doubt Claim? ❑ Yes ❑ No
Safeguard Description:	Scene Description:		Activity Description:	

Work Process Engaged In:	❑ Physical Training ❑ Training Exercise	❑ EMS Incident ❑ Fire Incident	❑ Station Maintenance ❑ Vehicle Maintenance	❑ Food Preparation ❑ Other_____	❑ WPE
Equipment Used:	❑ Turnout Gear ❑ Traffic Vest ❑ Other _____	❑ Exam Gloves ❑ Helmet	❑ N95 Mask ❑ SCBA	❑ Safety Shoes ❑ Ice Cleats	❑ Eye Protection ❑ PFD
Body Part Injured:	❑ Ankle ❑ Eye ❑ Hip ❑ Skull	❑ Back ❑ Face ❑ Knee ❑ Thigh	❑ Calf/Shin ❑ Foot ❑ Mouth ❑ Wrist	❑ Chest ❑ Hand ❑ Pelvis ❑ Other _____	❑ Elbow ❑ Heart ❑ Shoulder
Cause of Injury:	❑ Burn ❑ Motor Vehicle ❑ Miscellaneous _____	❑ Cold Exposure ❑ Strain	❑ Caught In/Under/Behind ❑ Struck By	❑ Cut/Puncture ❑ Stepped On	❑ Fall ❑ Struck Against
Treatment Description:					

Damage to Property: **(Attach additional forms for property)**

Owner's Name:	Owner's Home Address:			Owner's Phone:
Property Description:	Year:	Make:	Model:	Serial #:
Owner's Name (Last, First, M.I.):		Owner's Address:		
Owner's Email Address:		Cell Phone:		Photos Taken? ❑ Yes ❑ No

Rev. 06/23/22

Description of Object:					
Describe Damage: (Use other side if needed)					
Accident Date:	Accident Time:	Accident County:	Accident Location:		Incident #:
Investigating Police Officer:		Police Incident #:		Police Agency:	
Insurance Company:		Policy #:		Phone #:	

Witnessed? ❑ Yes ❑ No

Name:		Home Address:		Home/Cell Phone #:
Gender: ❑ M ❑ F	Email:		Was Individual Involved? ❑ Yes ❑ No	Work Phone #:
Name:		Home Address:		Home/Cell Phone #:
Gender: ❑ M ❑ F	Email:		Was Individual Involved? ❑ Yes ❑ No	Work Phone #:
Name:		Home Address:		Home/Cell Phone #:
Gender: ❑ M ❑ F	Email:		Was Individual Involved? ❑ Yes ❑ No	Work Phone #:

Brief Description How Incident Occurred:

Submitter Information:

Investigator Name:	Investigator Email Address:	Investigator Cell Phone #:
Investigator Title:	Investigator Department:	Investigator Work Phone #:

Investigator's Signature

Completed Fire Department Incident Form and Witness Statements must be scanned and emailed to: DFEMSIncident@CarrollCountyMD.gov within 24-hours of the event.