APPENDIX C

New Jersey Department of Health and Senior Services
Office of Emergency Medical Services
P.O. Box 360
Trenton, NJ 08625-0360

REPORTABLE EVENTS

In accordance with N.J.A.C. 8:40-3.7, you are required to complete this form, attach all relevant documents and deliver to the New Jersey Department of Health and Senior Services, Office of Emergency Medical Services within fourteen (14) calendar days of the accident, incident or other reportable event.

Provider Information

Date report filed: ____/____/____
Provider/Program Name: _____
Provider/Program Address: _____
Name and title of person filing report: _____

MAV
BLS Ambulance

Details of Accident/Incident

Accident/Incident date: ____/____/____ Time: _____am/pm
Accident/Incident location: _____

Type of Accident/Incident
Head-On Rear-end
Broadside Roll-over
Pedestrian Struck
Vehicle vs object
Other _____

Vehicle Location
Roadway Parked
Intersection
Other _____

Injuries
Yes No
If Yes (explain): _____

Status at time of Accident/Incident
Responding to 911 call Non-Emergency Transport
Enroute to medical facility with patient On Scene
Enroute to medical facility without patient
Responding for Non-Emergency Transport
Not on Assignment
Other _____

Vehicle Information

Veh #: _____ License Plate #: _____
VIN #: _____
Vehicle Out-of-Service? Yes No
If Yes (explain): _____

At Time of Accident
Emergency Lights On? Yes No
Was Siren On? Yes No

Use of Seatbelts
Driver: Yes No EMT Staff: Yes No
MICU Staff: Yes No Patient: Yes No
Other Passengers: Yes No
If No (explain): _____

Summary of Accident/Incident

REQUIRED DOCUMENTS (please attach)

Police report: Yes No If No (explain): _____

PCR FOR INJURED
(Patient Call Report)

Injured Patient(s): Yes No Injured Staff: Yes No Other Injuries: Yes No
If not attached, please explain: _____

CORRECTIVE ACTION
(To prevent recurrence, include completion dates)