

APPENDIX C

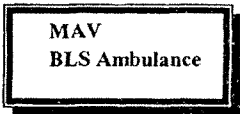
**New Jersey Department of Health and Senior Services
Office of Emergency Medical Services
P.O. Box 360
Trenton, NJ 08625-0360**

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: _____



| | | | | | |
|---|---|--|--|--|--|
| <p align="center">Details of Accident/Incident</p> <p>Accident/Incident date: ____/____/____ Time: ____ am/pm Accident/Incident location: _____</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 2px;"> <p><u>Type of Accident/Incident</u></p> Head-On Rear-end Broadside Roll-over Pedestrian Struck Vehicle vs object Other _____</td> <td style="width:50%; padding: 2px;"> <p><u>Vehicle Location</u></p> Roadway Parked Intersection Other _____</td> </tr> <tr> <td colspan="2" style="padding: 2px;"> <p><u>Injuries</u></p> Yes No If Yes (explain): _____</td> </tr> </table> <p align="center"><u>Status at time of Accident/Incident</u></p> 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 _____ | <p><u>Type of Accident/Incident</u></p> Head-On Rear-end Broadside Roll-over Pedestrian Struck Vehicle vs object Other _____ | <p><u>Vehicle Location</u></p> Roadway Parked Intersection Other _____ | <p><u>Injuries</u></p> Yes No If Yes (explain): _____ | | <p align="center">Vehicle Information</p> <p>Veh #: _____ License Plate #: _____ VIN #: _____ Vehicle Out-of-Service? Yes No If Yes (explain): _____</p> <p align="center">At Time of Accident</p> Emergency Lights On? Yes No Was Siren On? Yes No <p align="center">Use of Seatbelts</p> Driver: Yes No EMT Staff: Yes No MICU Staff: Yes No Patient: Yes No Other Passengers: Yes No If No (explain): _____ <p align="center">Summary of Accident/Incident:</p> _____ _____ _____ _____ _____ _____ _____ _____ |
| <p><u>Type of Accident/Incident</u></p> Head-On Rear-end Broadside Roll-over Pedestrian Struck Vehicle vs object Other _____ | <p><u>Vehicle Location</u></p> Roadway Parked Intersection Other _____ | | | | |
| <p><u>Injuries</u></p> Yes No If Yes (explain): _____ | | | | | |
| <p><u>REQUIRED DOCUMENTS (please attach)</u></p> Police report: Yes No If No (explain): _____ | | | | | |
| <p>PCR FOR INJURED (Patient Call Report)</p> Injured Patient(s): Yes No Injured Staff: Yes No Other Injuries: Yes No If not attached, please explain: _____ | | | | | |
| <p><u>CORRECTIVE ACTION</u> (To prevent recurrence, include completion dates)</p> _____ _____ _____ _____ _____ | | | | | |