

# VOLUNTEER FIRE & RESCUE, WASHINGTON COUNTY, MD

## VEHICLE INCIDENT/NEAR MISS REPORT FORM

- NEAR MISS  
 INCIDENT


**IMMEDIATELY FAX TO:**  
**COUNTY RISK MGMT @ 240-313-2351**  
 Or email to: [bmaginnis@washco-md.net](mailto:bmaginnis@washco-md.net)

FOR RISK MGMT USE ONLY:  
 Date Rec'd by Risk Mgmt \_\_\_\_\_ Carrier: \_\_\_\_\_  
 Date Rptd to Carrier \_\_\_\_\_ Policy # \_\_\_\_\_


### SECTION 1: AUTHORIZED OPERATOR AND INCIDENT INFORMATION

FIRE & RESCUE OPERATOR'S NAME :				DATE OF INCIDENT		TIME <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
CURRENT STREET (RESIDENCE) ADDRESS			CITY		STATE	ZIP	HOME PHONE:
CO #	DEPARTMENT NAME & STREET ADDRESS:				CITY		STATE ZIP
DEPARTMENT TELEPHONE #:	DEPARTMENT FAX #:	SUPERVISOR NAME:			SUPERVISOR TELEPHONE:		
CITY/STATE/COUNTY (if applicable) WHERE OCCURRED			STREET OR HWY.		MILEPOST NO.	INTERSECTION/ NEAREST STREET/ROAD	
DRIVER'S LICENSE NUMBER			STATE ISSUED	DATE OF BIRTH:	EXPIRATION DATE		

### SECTION 2: FIRE & RESCUE VEHICLE INFORMATION (VEHICLE #1)

YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE	
VEHICLE IDENTIFICATION NUMBER (VIN)			WHERE CAN VEHICLE BE SEEN?	WHEN:	
DESCRIBE DAMAGE		ESTIMATE \$	CIRCLE AREAS OF VEHICLE DAMAGE:		
		REPAIR SHOP:			
Vehicle towed ? <input type="checkbox"/> YES <input type="checkbox"/> NO					

### SECTION 3: OTHER (CLAIMANT) VEHICLE INFORMATION (VEHICLE #2)

YEAR	MAKE	MODEL	LICENSE PLATE #	VIN#	WHERE/WHEN CAN VEHICLE BE SEEN:	
NAME OF VEHICLE OWNER		ADDRESS		CITY	STATE/ZIP	HOME AND WORK PHONE
NAME OF DRIVER		ADDRESS		CITY	STATE/ZIP	HOME AND WORK PHONE
DRIVER'S LICENSE NUMBER	STATE	EXP DATE:	DATE OF BIRTH:	INSURANCE COMPANY & POLICY #:		AGENT & TELEPHONE #:
DESCRIBE DAMAGE		ESTIMATE \$	CIRCLE AREAS OF VEHICLE DAMAGE:			
		REPAIR SHOP:				
Vehicle towed ? <input type="checkbox"/> YES <input type="checkbox"/> NO						

### SECTION 4: AUTHORIZED OPERATOR'S DESCRIPTION

In your own words, please describe how the incident occurred. If necessary, attach an additional page.

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Authorized Operator's Signature	Date
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**SECTION 5: OTHER NON-VEHICLE DAMAGE**

WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? <input type="checkbox"/> If so, please indicate what type of property was damaged: Building <input type="checkbox"/> Fence <input type="checkbox"/> Guard rail <input type="checkbox"/> Other _____	DESCRIBE DAMAGE AND PROVIDE ESTIMATED REPAIR COSTS:
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NAME OF OWNER	ADDRESS	CITY	PHONE
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**SECTION 6: INJURED PARTIES (LIST ALL INJURIES, IF ANY -- INCLUDING AUTHORIZED OPERATOR)**

NAME (Attach additional sheets if necessary) /ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
HOME WORK								
HOME WORK								

**SECTION 7: WITNESSES AND PERSONS WITH KNOWLEDGE OF LIABILITY OR DAMAGE FACTS**

NAME (Attach additional sheets if necessary)	ADDRESS	CITY	PHONE
			HOME WORK
			HOME WORK

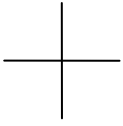
**SECTION 8: INCIDENT TYPE AND AVOIDANCE ACTIONS**

<b>Check as many as apply:</b>	<b>TYPE:</b> <input type="checkbox"/> Front to rear <input type="checkbox"/> Head-on <input type="checkbox"/> Parked car <input type="checkbox"/> Pedestrian <input type="checkbox"/> Backing <input type="checkbox"/> Pulling Out/In <input type="checkbox"/> Broadside <input type="checkbox"/> Sideswipe <input type="checkbox"/> Bike-car <input type="checkbox"/> Stationary object <input type="checkbox"/> Struck while Parked <input type="checkbox"/> Intersection <input type="checkbox"/> Lane Change <input type="checkbox"/> Road hazard <input type="checkbox"/> Struck animal <input type="checkbox"/> Theft/Vandalism		
1. If pedestrian, where was he (crosswalk, etc.)	<b>#1 YOUR VEHICLE</b>	<b>#2 OTHER PARTY (NAME)</b>	<b>#3 OTHER PARTY (NAME)</b>
2. At what distance was danger first noticed?			
3. Speeds at time danger was first noticed?			
4. Speeds at time of incident?			
5. What warning signals given?			
6. Obstruction to vision (weather and other)?			
7. Lights on? Wipers on? Windows fogged?			
8. Had any party been drinking? Who?			
9. What actions taken to avoid incident?			

**SECTION 9: INCIDENT DATA**

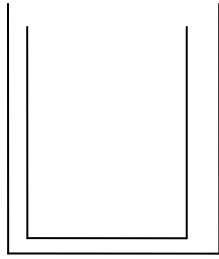
LIGHT CONDITIONS (check one)	TRAFFIC CONTROL	TYPE OF ROAD (check one or more)	VEHICLE CONDITION (check one or more)	ROAD SURFACE (check one)	WEATHER (check one)
1. <input type="checkbox"/> Daylight	#1 #2 VEHICLE <input type="checkbox"/> 1 <input type="checkbox"/> Signals	#1 #2 VEHICLE <input type="checkbox"/> 1 <input type="checkbox"/> One way	#1 #2 VEHICLE <input type="checkbox"/> 1 <input type="checkbox"/> Defective brakes	#1 #2 VEHICLE <input type="checkbox"/> 1 <input type="checkbox"/> Dry	1 <input type="checkbox"/> Clear, cloudy and overcast
2. <input type="checkbox"/> Dawn	<input type="checkbox"/> 2 <input type="checkbox"/> Stop sign	<input type="checkbox"/> 2 <input type="checkbox"/> Two way	<input type="checkbox"/> 2 <input type="checkbox"/> Defective headlights	<input type="checkbox"/> 2 <input type="checkbox"/> Wet	2 <input type="checkbox"/> Raining
3. <input type="checkbox"/> Dusk	<input type="checkbox"/> 3 <input type="checkbox"/> Flashing red	<input type="checkbox"/> 3 <input type="checkbox"/> Reversible road	<input type="checkbox"/> 3 <input type="checkbox"/> Defective rear lights	<input type="checkbox"/> 3 <input type="checkbox"/> Snow	3 <input type="checkbox"/> Snowing
4. <input type="checkbox"/> Dark, street lights on	<input type="checkbox"/> 4 <input type="checkbox"/> Flashing amber	<input type="checkbox"/> 4 <input type="checkbox"/> Interchange loop ramp	<input type="checkbox"/> 4 <input type="checkbox"/> Tires worn	<input type="checkbox"/> 4 <input type="checkbox"/> Ice	4 <input type="checkbox"/> Fog
5. <input type="checkbox"/> Dark, street lights off	<input type="checkbox"/> 5 <input type="checkbox"/> RR signal	<input type="checkbox"/> 5 <input type="checkbox"/> Alley/Parking lot	<input type="checkbox"/> 5 <input type="checkbox"/> Punctured or blown tires	<input type="checkbox"/> 5 <input type="checkbox"/> Other (specify)	5 <input type="checkbox"/> Other (specify)
6. <input type="checkbox"/> Dark, no street lights	<input type="checkbox"/> 6 <input type="checkbox"/> Officer/flagman	<input type="checkbox"/> 6 <input type="checkbox"/> Two way left turn lanes	<input type="checkbox"/> 6 <input type="checkbox"/> Other (specify)	NAME OF INVESTIGATING POLICE AGENCY	
7. <input type="checkbox"/> Other (specify)	<input type="checkbox"/> 7 <input type="checkbox"/> Yield sign	<input type="checkbox"/> 1 <input type="checkbox"/> Separated		INVESTIGATING AGENCY REPORT NO.	
	<input type="checkbox"/> 8 <input type="checkbox"/> No traffic control	<input type="checkbox"/> 2 <input type="checkbox"/> Divided			
	<input type="checkbox"/> 9 <input type="checkbox"/> Other	<input type="checkbox"/> 3 <input type="checkbox"/> Undivided			

## GRID DIAGRAM FOR YOUR USE (Show your vehicle as #1)



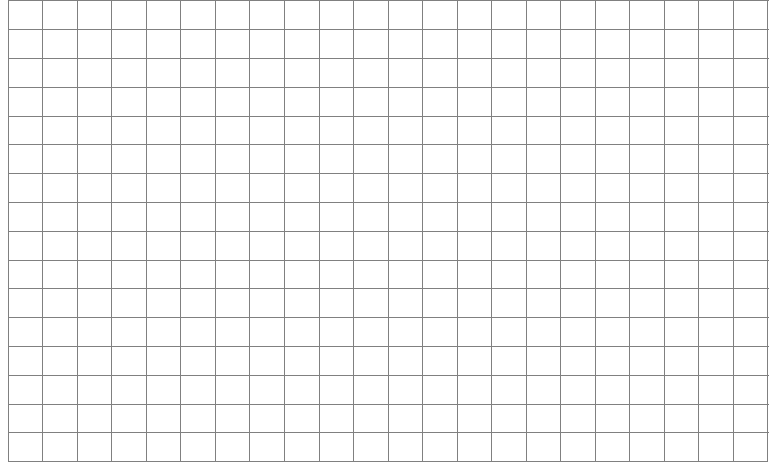
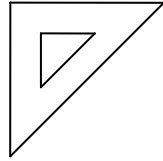
Indicate points of compass: N, E, S, W

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.



**IMPORTANT:** If street or view was obstructed in any way, indicate where and how, also indicate any street, cars or tracks and traffic signal or signs.

You may wish to draw a separate diagram on another piece of paper.



## SECTION 10: SUPERVISOR'S INVESTIGATION

UNSAFE DRIVING ACT	
F&R Clmt	
<input type="checkbox"/>	<input type="checkbox"/> Driving too fast – or too slow
<input type="checkbox"/>	<input type="checkbox"/> Did not grant right of way
<input type="checkbox"/>	<input type="checkbox"/> Followed too closely
<input type="checkbox"/>	<input type="checkbox"/> Improper passing
<input type="checkbox"/>	<input type="checkbox"/> On wrong side of road or land
<input type="checkbox"/>	<input type="checkbox"/> Failed to give proper signal
<input type="checkbox"/>	<input type="checkbox"/> Improper turn
<input type="checkbox"/>	<input type="checkbox"/> Disregarded traffic signal or control
<input type="checkbox"/>	<input type="checkbox"/> Improper starting from parked position
<input type="checkbox"/>	<input type="checkbox"/> Improper backing maneuver
<input type="checkbox"/>	<input type="checkbox"/> Other improper actions _____
<hr/>	
<input type="checkbox"/>	<input type="checkbox"/> No improper driving or parking
	F&R Clmt      F&R Clmt
Seat belts worn: Yes: <input type="checkbox"/> <input type="checkbox"/> No: <input type="checkbox"/> <input type="checkbox"/>	

CAUSE OF UNSAFE DRIVING ACT	
F&R Clmt	
<input type="checkbox"/>	<input type="checkbox"/> Driving under influence
<input type="checkbox"/>	<input type="checkbox"/> Untrained or unskilled
<input type="checkbox"/>	<input type="checkbox"/> Abstracted-distracted
<input type="checkbox"/>	<input type="checkbox"/> Hurry or impatience
<input type="checkbox"/>	<input type="checkbox"/> Aggressive driving/irritated driving
<input type="checkbox"/>	<input type="checkbox"/> Fatigue – long driving. Lack of sleep
<input type="checkbox"/>	<input type="checkbox"/> Other causes: _____
<hr/>	
<input type="checkbox"/>	<input type="checkbox"/> No unsafe driving act

What action has or will be taken to prevent recurrence: (Attach separate sheet if more space is needed:

Did your investigation find any discrepancy between the Authorized Operator's statement and actual event?  YES  NO  
If "Yes", please provide details.

Supervisor's Signature	Title	Date
Supervisor's Printed Name	Department	
Authorized Operator's Signature	Date	