



CARROLL COUNTY Department of Fire & EMS



VEHICLE COLLISION INFORMATION FORM

Reporting: Vehicle Accident Non-Collision Damage

DFEMS Vehicle: County-Owned Company-Owned Personal

Vehicle ID:		Co. Property #:		Year:		Make:		Model:		VIN:	
Driver's Name (Last, First, M.I.):						Driver's Home Address:				Plate #:	
Driver's License # & State:				Employee ID:		MIEMSS #:		DOB:		Home Phone:	
Driver's E-mail Address:						Status (FT,PT,Vol):		Station and Shift:		Work Phone:	
Supervisor's Name:				Supervisor's Phone:		Supervisor's Title:				Cell Phone:	
Accident Date:		Accident Time:		Accident County:		Accident Location:				# Hours On Duty?	Incident #:
Investigating Police Officer:				Police Agency:				Police Incident #:			
Were charges filed?: <input type="checkbox"/> Yes <input type="checkbox"/> No						# of Vehicles Involved:		Any Vehicle Towed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Specify Charges:						<input type="checkbox"/> Employee/Volunteer <input type="checkbox"/> Other Driver					
Describe Damage to DFEMS Vehicle: (Use other side if needed)								Drug Test? <input type="checkbox"/> Yes <input type="checkbox"/> No		Photos Taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Damage to Other Vehicle or Property: (Attach additional forms for multiple vehicles or property)

Owner's Name:				Owner's Home Address:				Owner's Phone:			
Driver's Name:				Driver's Home Address:				Driver's Phone:			
Drivers License # & State:				Email Address:				DOB:			
Year:	Make:	Model:	VIN:		Tag# & State:		Cell/Home Phone:				
Description of Object:								Work Phone:			
Insurance Company				Policy #				Phone #		Photos Taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Damage to Other Vehicle or Property: (Attach additional forms for multiple vehicles or property)

Owner's Name:				Owner's Home Address:				Owner's Phone:			
Driver's Name:				Driver's Home Address:				Driver's Phone:			
Drivers License # & State:				Email Address:				DOB:			
Year:	Make:	Model:	VIN:		Tag# & State:		Cell/Home Phone:				
Description of Object:								Work Phone:			
Insurance Company				Policy #				Phone #		Photos Taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Any Injuries? Yes No

# Of Employees	# Of Civilians	# Of Employees Transported	# Of Civilians Transported	Transported to Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name:		Home Address:		Phone:
Name:		Home Address:		Phone:

Witnessed? Yes No

Name:		Home Address:		Home/Cell Phone #:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Email:		Was Individual Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone #:	
Name:		Home Address:		Home/Cell Phone #:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Email:		Was Individual Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone #:	
Name:		Home Address:		Home/Cell Phone #:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Email:		Was Individual Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone #:	

Conditions:

Road Type:	<input type="checkbox"/> Paved	<input type="checkbox"/> Unpaved	<input type="checkbox"/> Residential	<input type="checkbox"/> Commercial	<input type="checkbox"/> Highway
Road Conditions:	<input type="checkbox"/> Dry	<input type="checkbox"/> Wet	<input type="checkbox"/> Ice	<input type="checkbox"/> Snow Covered	<input type="checkbox"/> Mud
Weather Conditions:	<input type="checkbox"/> Clear/Cloudy	<input type="checkbox"/> Foggy	<input type="checkbox"/> Raining	<input type="checkbox"/> Snow/Sleet	<input type="checkbox"/> Windy
Traffic Control:	<input type="checkbox"/> Traffic Light	<input type="checkbox"/> Stop Sign	<input type="checkbox"/> Yield	<input type="checkbox"/> Uncontrolled	
Light Conditions:	<input type="checkbox"/> Daylight	<input type="checkbox"/> Dark	<input type="checkbox"/> Dawn	<input type="checkbox"/> Dusk	
Response Mode:	<input type="checkbox"/> Lights & Siren	<input type="checkbox"/> Lights only	<input type="checkbox"/> Non-Emergency	<input type="checkbox"/> Parked	<input type="checkbox"/> Backing
Spotter:	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Brief Description How Collision Occurred:

Submitter Information:

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

Investigator's Signature

Completed On-Duty Injury Form and Witness Statements must be scanned and emailed to: DFEMSincident@CarrollCountyMD.gov within 24-hours of the injury.