

**CITY OF PHOENIX, ARIZONA
FIRE DEPARTMENT
INJURY REPORT**

DISTRIBUTION
WHITE - PAYROLL
YELLOW - SAFETY
PINK - CITY SAFETY

LAST NAME		FIRST	M.I.	S.S.N.		BIRTH DATE MO. DAY YEAR		COMPANY	SHIFT	JOB TITLE		
HOME ADDRESS (NUMBER & STREET)						CITY		STATE	ZIP CODE	PHONE NO.		
SEX: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	MARITAL STATUS:		NO. OF DEPENDENTS:		ACCIDENT: MO. DAY		DATE OF INJURY YEAR		TIME A.M. P.M.	DATE EMPLOYER NOTIFIED	LAST DATE WORKED	PROBABLE RETURN DATE
NUMBER OF CONSECUTIVE HOURS ON DUTY: <input type="checkbox"/> 24, <input type="checkbox"/> 24-26, <input type="checkbox"/> 36-48, <input type="checkbox"/> 48-60, <input type="checkbox"/> 60-72, <input type="checkbox"/> 72				OVERTIME AWR CM	YES <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	NO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	EMPLOYER PREMISES	<input type="checkbox"/> YES <input type="checkbox"/> NO	LOSS TIME (HOURS)	DR. TREATED	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ACCIDENT OR LOCATION OF INCIDENT (City, County, State, Zip Code)						INCIDENT #		ATTENDING PHYSICIAN				

NOTE: If medical attention is required after submitting this Preliminary Injury Report you must report the doctor's name and address to the District Commander's office.

INJURY OCCURRED WHERE:	PART OF BODY:	SIDE		SOURCE OF INJURY:	NATURE OF INJURY:
		L	R		
01 At Station / Workstation	01 Skull			01 Vehicle accident	01 Strain, sprain
02 Responding to a call	02 Scalp			02 Chemical exposure	02 Cuts, abrasions, lacerations
03 Returning from a call	03 Brain			03 Infectious exposure	03 Punctures
04 Hazmat incident	04 Face			04 Lifting	04 Fracture or dislocations
05 Operating on scene	05 Eye(s)			05 Pulling	05 Contusions, bruise
07 Special duty assignment	06 Teeth			06 Fall	06 Bleeding
08 Physical fitness facility	07 Mouth			07 Structured collapse	07 Burns, (chemical)
09 Station training indoor/outdoor	08 Nose			08 Hand tools	08 Burns, (heat)
10 Academy training	09 Ear(s)			09 Powered tools	09 Fatigue/exhaustion
11 Operating on EMS call	10 Neck			10 Equipment failure	10 Heart attack/stroke
12 Special operations events	11 Chest			11 Noise	11 Electric shock
99 Other (explain)	12 Heart			12 Particles	12 Concussion
	13 Shoulder			13 Tennis	13 Dermatitis
INJURY OCCURRED WHILE:	14 Upper Arm			14 Racquetball	14 Hearing loss/impairment
01 Patient care	15 Elbow			16 Running	15 Heat stroke
02 Firefighting	16 Forearm			17 Weight training	16 Heat exhaustion/cramps
03 Physical Fitness	17 Wrist(s)			18 Personal apparel	17 Contagious, infectious disease
04 Extrication	18 Hand(s)			19 Medications, etc.	18 Internal injury
05 Ventilating roof	19 Finger(s)			20 Heat, radiant	19 Respiratory tract
06 Overhauling	20 Abdomen			21 Heat, steam	20 Body system
07 Station activities	21 Upper back			22 Heat, day temperature	21 Brain injury
08 Pulling hose	22 Lower back			23 Smoke inhalation	98 Multiple injuries
09 Forcible entry	23 Buttocks			24 Falling objects	99 Other (explain)
10 Working with ladders	24 Groin			25 Climbing	SPECIFY TOOL OR SUBSTANCE MOST CLOSELY CONNECTED WITH INCIDENT:
11 Other	25 Genitalia			26 Volleyball	
13 Inspections	26 Thigh/femur			98 Sudden position change	
12 Hydrant Testing	27 Knee(s)			99 Other (explain)	
SEVERITY INDEX:	28 Lower leg(s)				
01 Precautionary Report	29 Ankle(s)				
02 Treated, no lost time	30 Foot/Feet				
03 Treated, lost balance of shift	31 Lungs				
04 Treated, lost balance (+) add'l. shifts	98 Multiple parts				
05 Admitted to hospital	99 Other (explain)				
06 Fatal					

LIST WITNESSES BELOW:	
NAME	ADDRESS
NAME	ADDRESS

BRIEFLY DESCRIBE WHAT YOU WERE DOING AT TIME OF ACCIDENT TO INCLUDE ANY CONDITIONS OR ACTS WHICH MAY HAVE BEEN CONTRIBUTING FACTORS:

OTHER EXPLAINED:

IF INJURY REPORTED LATE GIVE REASON FOR DELAY:

SUPERVISOR'S NAME: _____ SUPERVISOR SIGNATURE: _____

I ATTEST THE FOLLOWING STATEMENTS ARE TRUE (SIGNED) _____ DATE _____