



# INJURY REPORT

State of Connecticut  
 Commission on Fire Prevention and Control  
 Connecticut Fire Academy

Phone: 860-627-6363  
 Fax: 860-654-1889

<b>INJURED PARTY</b>	Name (Last)	(First)	(M.I.)	Social Security Number	Date of Birth
	Address (No. and Street)		(City or Town)	(State)	(Zip Code)
<b>DATE OF INJURY:</b>	Injured Party is			Injured Party Fire Department	
	<input type="checkbox"/> Instructor	<input type="checkbox"/> CFA Student	<input type="checkbox"/> Non-Student	<input type="checkbox"/> Staff	
	Course Name			Instructor Name	

**A. Nature of Injury**

1. <input type="checkbox"/> Strain, Sprain, Bruise	7. <input type="checkbox"/> Eye Injury
2. <input type="checkbox"/> Cuts, Abrasion, Laceration	8. <input type="checkbox"/> Burns
3. <input type="checkbox"/> Inhalation, Smoke	9. <input type="checkbox"/> Fractures
4. <input type="checkbox"/> Inhalation, Fumes	10. <input type="checkbox"/> Multiple Injury
5. <input type="checkbox"/> Heat Exhaustion-Fatigue	11. <input type="checkbox"/> Recurrence
6. <input type="checkbox"/> Punctures	12. <input type="checkbox"/> Other _____

**D. Falls**

1.  In Holes
2.  Over Materials
3.  On Wet Surface
4.  On Icy Surface
5.  On Slippery Surface
6.  Lost Balance
7.  Tool, Equipment Slipped
8.  On Steps
9.  From Ladder
10.  From Apparatus
11.  Other \_\_\_\_\_

**E. Contact With**

1.  Chemicals
2.  Electricity
3.  Heat or Flame
4.  Glass
5.  Water—Liquids
6.  Metal—Hot Pipes
7.  Nails, Tin, etc.
8.  Ran/walk into
9.  Other \_\_\_\_\_

**B. Where Injury Occurred**

1. <input type="checkbox"/> Fire Station	7. <input type="checkbox"/> Tower
2. <input type="checkbox"/> Extraction Area	8. <input type="checkbox"/> Multi-Purpose Room
3. <input type="checkbox"/> Burn Building	9. <input type="checkbox"/> Outside Props
4. <input type="checkbox"/> Exercise Area	10. <input type="checkbox"/> Admin. Building
5. <input type="checkbox"/> Lodging Area	11. <input type="checkbox"/> Parking Lot
6. <input type="checkbox"/> Class Room	12. <input type="checkbox"/> Other _____

**F. Struck (by, with or against)**

1. <input type="checkbox"/> Pulling Ceiling	7. <input type="checkbox"/> Apparatus
2. <input type="checkbox"/> Glass, other particles	8. <input type="checkbox"/> Tool(s)
3. <input type="checkbox"/> Chemicals	9. <input type="checkbox"/> Falling Glass
4. <input type="checkbox"/> Water Stream	10. <input type="checkbox"/> Falling Object
5. <input type="checkbox"/> Ladder in service	11. <input type="checkbox"/> Thrown Object
6. <input type="checkbox"/> Ladder on Apparatus	12. <input type="checkbox"/> Other _____

**C. Body Area Affected**

1. <input type="checkbox"/> Multiple Parts	13. <input type="checkbox"/> Groin	
2. <input type="checkbox"/> Head	14. <input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Arm
3. <input type="checkbox"/> Face	15. <input type="checkbox"/> Left Elbow	<input type="checkbox"/> Right Elbow
4. <input type="checkbox"/> Left Eye <input type="checkbox"/> Right Eye	16. <input type="checkbox"/> Left Wrist	<input type="checkbox"/> Right Wrist
5. <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear	17. <input type="checkbox"/> Left Hand	<input type="checkbox"/> Right Hand
6. <input type="checkbox"/> Neck	18. <input type="checkbox"/> Left Finger	<input type="checkbox"/> Right Finger
7. <input type="checkbox"/> Shoulder	19. <input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg
8. <input type="checkbox"/> Chest	20. <input type="checkbox"/> Left Knee	<input type="checkbox"/> Right Knee
9. <input type="checkbox"/> Lungs	21. <input type="checkbox"/> Left Ankle	<input type="checkbox"/> Right Ankle
10. <input type="checkbox"/> Abdomen	22. <input type="checkbox"/> Left Foot	<input type="checkbox"/> Right Foot
11. <input type="checkbox"/> Back	23. <input type="checkbox"/> Left Toe	<input type="checkbox"/> Right Toe
12. <input type="checkbox"/> Buttocks	24. <input type="checkbox"/> Other _____	

**G. Exposure or Over Exertion**

1. <input type="checkbox"/> Fatigue	7. <input type="checkbox"/> Unusual weather
2. <input type="checkbox"/> Lifting	8. <input type="checkbox"/> Unusual Fumes
3. <input type="checkbox"/> Pulling	9. <input type="checkbox"/> Other _____
4. <input type="checkbox"/> Making Rescue	
5. <input type="checkbox"/> SCBA-too late	
6. <input type="checkbox"/> SCBA-not used	

<b>MANDATORY BE SPECIFIC ACCIDENT LOCATION</b>	
--	--

What was injured party doing?

**(Describe fully and mention any item connected accident) use more paper if needed**

How did injury occur? **(Describe fully)**

Was the person hospitalized? Yes  No

If yes, which one? \_\_\_\_\_

How were they transported? Car  Ambulance

Who transported them? \_\_\_\_\_

Were they admitted? Yes  Released

Department notified? Yes  No  Person Notified/Title \_\_\_\_\_

What corrective action has been taken? What suggestions do you have to avoid this type of injury?

\_\_\_\_\_  
**Instructor's Name (Print)**

\_\_\_\_\_  
**Instructor's Signature**

\_\_\_\_\_  
**Instructor's Date**

\_\_\_\_\_  
**Injured's Name (Print)**

\_\_\_\_\_  
**Injured's Signature**

\_\_\_\_\_  
**Injured's Date**

### **Injury Refusal Report**

I \_\_\_\_\_ (print name) acknowledge that I have been offered further medical treatment and/or transportation to a medical facility by a member of the Connecticut Fire Academy staff and that I have declined the offer. I accept full responsibility for my decision.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Name ( Print)**

\_\_\_\_\_  
**Witness Signature**