Date Received ________________________

Department Director ___________________
(*Signature*)

Town of Topsham
Emergency Medical Services/Accident Report

Date _____/_____/_____ Program Name ____________________________________

Volunteer / Coach _____________________ Phone ______________________________

Injured Person's Full Name ____

Phone ____________________ Address ____

D.O.B. ___________________ ____

If under 18 please list Parent / Guardian ____

Phone ____________________ Address ____

(If different) ____

Incident Location ____ Time __________________________

Complaint / Injury ____

Treatment Offered:

Name of person who provided care ____

______________________________ Were you exposed to Blood / Body Fluids ☐ Yes ☐ No

(Signature of treating individual)

Transported by _________________________________ to ___________________________________

Released to ____________________________________

(*Signature)*

Account of Incident:

(Continue on back if needed)