

This report is to be completed when an occupational or training medical incident occurs. If a student or employee is injured, a "Medical Incident Report" must be submitted. The Lead Instructor for the class or the employee's supervisor must complete the form on his/her behalf. The student or employee may request a copy of the report later after the filing of the report and it receives a report number. Incident Reporting ensures there is a record on file with the fire academy. This form in no way waives the student or employee's right to workers' compensation benefits. Filing of a medical incident report is not a filing of a workers' compensation claim. A student or an employee retains his/her right to file a workers' compensation claim at a later date.

If an injury occurs, first aid may be appropriate treatment. "First aid" means any one-time treatment for minor scratches, cuts, burns, splinters, or other minor medical injuries, which do not ordinarily require medical care. This one-time treatment is considered first aid even though provided by an Emergency Responder or a medically trained academy employee. Please complete each section of this form.

**South Carolina Fire Academy
MEDICAL / INCIDENT REPORT**

Report Number: _____
(Filled out by Safety Chairperson)

STUDENT / EMPLOYEE INFORMATION					
On Site: <input type="checkbox"/> Off Site: <input type="checkbox"/>	Training Location:	Training Incident: <input type="checkbox"/>	Non Training Incident: <input type="checkbox"/>		
Name (First):	Name (Last):	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Home Address:	Street:	City:	State:	Zip:	
Home phone:	Work Number:	Dept Name:	Job Title:		
INCIDENT INFORMATION					
Date of Incident:		Time of Incident:		Course Code and Section Number:	
Was Incident Reported to Regional Supervisor: <input type="checkbox"/> Yes <input type="checkbox"/> No			Date:		Time:
Was there a witness to the Incident: <input type="checkbox"/> Yes <input type="checkbox"/> No			Witness Name:		
Did the Student or employee lose class time or work. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Was defective equipment involved? <input type="checkbox"/> Yes <input type="checkbox"/> No			Was maintenance notified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What was the defective equipment that was involved?					
Subject to Attorney Client Privilege					

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LEAD INSTRUCTOR OR SUPERVISOR COMPLETES THIS SECTION

INITIAL FIRST AID CARE

Describe First Aid given and the type of injury or chief complaint:

No First Aid needed - Reporting Only Declining First Aid at this time Follow up care recommended

BP: Time: BP: Time: BP: Time:

Pulse Rate: Breathing Rate: Pulse Rate: Breathing Rate:

Was an AED Used: Yes No Was a BVM Used: Yes No

Printed Name of Lead Instructor: _____ **Phone:** _____

Date: _____ **Signature of Lead Instructor:** _____



OFF SITE MEDICAL INFORMATION SECTION

Was transport to a treatment facility provided for this injury No Yes Not Required

How was transportation provided? EMS POV Not Required

Did student or employee receive treatment off site: Yes No Unknown Not required

Note: If, initially, first aid is declined or rendered but at a later date, treatment beyond first aid is required, the student or employee should contact their supervisor. Seeking first aid treatment and completion of this report does not waive the employee's right to file a workers' compensation claim and seek benefits in accordance with statutory workers' compensation laws.

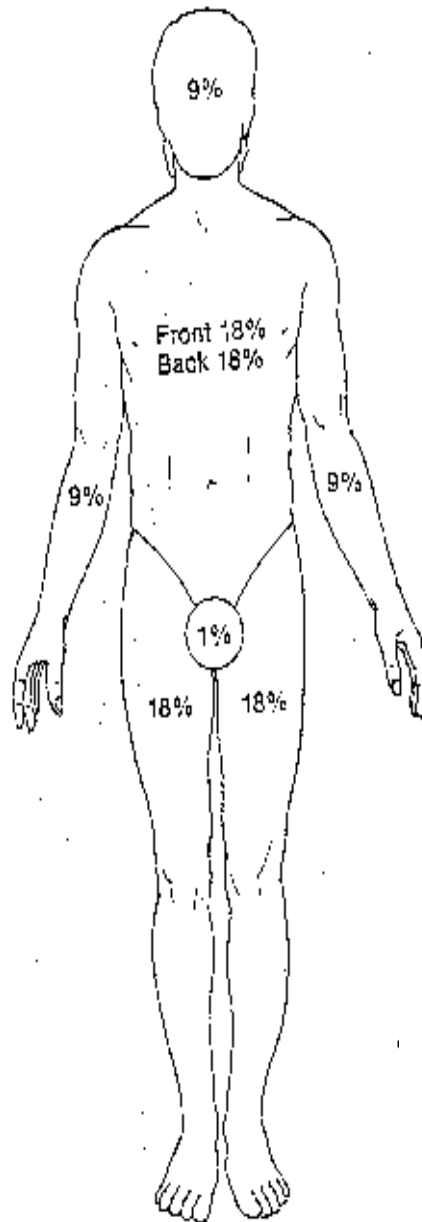
Additional notes related to Off Site Medical Information:

- Distribution:**
- Reviewed by the Resident Manager: _____ Date: _____
 - Reviewed by the Regional Supervisor: _____ Date: _____
 - Reviewed by the Superintendent: _____ Date: _____
 - Reviewed by the Safety Committee Chairperson: _____ Date: _____

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MEDICAL / INCIDENT REPORT**

**Silhouette of the Human Body
Used To Indicate Injury or Burn Location**



ADULT

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