

ROCKLAND FIRE DEPARTMENT
INCIDENT REPORT

Today's date:	_____	Date & time of injury:	_____
Employer	ROCKLAND FIRE	Contact tel. #:	_____
Employee:	_____	SSN: xxx-xx	_____
Home address:	_____ _____ _____	DOB:	_____
		Personal tel. #:	_____
Date of disability:	_____	EMAIL:	_____
Nature of injury/illness:	_____ _____		
Body parts affected:	_____		
Address where occurred:	_____		
Weather conditions:	_____		
Witnesses:	_____		
Incident description:	_____ _____		
Was medical treatment sought? ☐ Yes or ☐ No			
If yes, where? _____		by whom? _____	
Employee signature:	_____	Date:	_____
Supervisor signature:	_____	Date:	_____

Please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an insurance claim application may be guilty of a crime and may be subject to fines and/or imprisonment.

Gowrie Claims Services
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