Appendix #1

*MAINE CRIMINAL JUSTICE ACADEMY*

***ACCIDENT / ILLNESS REPORT FORM & CHECK LIST***

**DATE OF REPORT**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STUDENT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Male / Female**: \_\_\_\_\_ **Age**: \_\_\_\_ **MCJA PROGRAM:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INJURY INFORMATION**:

**Date** **of Injury**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Time** **of Injury**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Location:** where accident / incident occurred:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe in detail** how the accident / incident occurred (use additional paper if necessary)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Pre-Existing Injury? Y N*** *If yes, explain*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SUSPECTED CAUSE OF INJURY /ILLNESS (check all that apply)**

* BLUNT TRAUMA\_\_\_\_\_\_
* EXPOSURE\_\_\_\_\_\_
* FALL\_\_\_\_\_\_
* HYPER-EXTENSION\_\_\_\_\_\_
* HYPER -FLEX\_\_\_\_\_\_
* NON-INJURY AILMENT\_\_\_\_\_\_
* ROTATION\_\_\_\_\_\_
* SYSTEMIC ILLNESS\_\_\_\_\_\_
* OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNS AND SYMPTOMS (check all that apply)**

* ABDOMINAL INVOLVEMENT \_\_\_\_\_
* ABRASION\_\_\_\_\_
* BLEEDING\_\_\_\_\_\_
* BURN\_\_\_\_\_\_
* CONTUSION\_\_\_\_\_
* CONVULSION\_\_\_\_\_
* CRUSHED\_\_\_\_\_
* FRACTURE\_\_\_\_\_\_
* DISCOLORATION\_\_\_\_\_
* DISLOCATION\_\_\_\_\_
* HEAD INJURY\_\_\_\_\_
* HEARING DISTURBANCES\_\_\_\_\_
* LACERATION\_\_\_\_\_
* LUNG INVOLVEMENT \_\_\_\_\_
* NUMBNESS\_\_\_\_\_
* PAIN\_\_\_\_\_
* SHOCK\_\_\_\_\_
* SPRAIN\_\_\_\_\_
* STRAIN\_\_\_\_\_
* SWELLING\_\_\_\_\_
* VISUAL DISTURBANCES\_\_\_\_\_
* VOMITING / NAUSEA\_\_\_\_\_\_
* OTHER\_\_\_\_\_

EXPLANATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SITE OF INJURY / ILLNESS (check all that apply)**

* ABDOMEN\_\_\_\_\_
* ANKLE\_\_\_\_\_
* BACK\_\_\_\_\_\_
* BODY\_\_\_\_\_
* CHEST\_\_\_\_\_\_\_\_
* EARS\_\_\_\_\_
* ELBOW\_\_\_\_\_\_\_\_
* EYES\_\_\_\_\_\_
* FACE\_\_\_\_\_\_
* FINGERS\_\_\_\_\_\_
* FOOT\_\_\_\_\_\_\_\_\_
* FRONT\_\_\_\_\_
* HAND\_\_\_\_\_\_\_\_
* HEAD­­­­­­­­­­\_\_\_\_\_\_
* KNEE\_\_\_\_\_\_
* LOWER ARM\_\_\_\_\_
* LOWER LEG\_\_\_\_\_
* MOUTH\_\_\_\_\_
* NECK\_\_\_\_\_\_\_\_\_
* NOSE\_\_\_\_\_
* RIBS­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_
* SHOULDER\_\_\_\_\_\_
* SIDE\_\_\_\_\_\_\_
* TOES\_\_\_\_\_\_\_\_\_\_
* UPPER ARM\_\_\_\_\_
* UPPER LEG\_\_\_\_\_
* WRIST\_\_\_\_\_\_\_\_\_
* NONE\_\_\_\_\_
* OTHER: explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROCEDURES TAKEN (check all that apply)**

* AIRWAY OPENED / CLEARED \_\_\_\_\_
* ARTIFICIAL VENTILATION \_\_\_\_\_
* BLEEDING CONTROLLED \_\_\_\_\_
* CPR\_\_\_\_\_
* DRESSING APPLIED\_\_\_\_\_
* ELEVATION\_\_\_\_\_\_
* IMMOBILIZATION\_\_\_\_\_
* MOTION TESTING \_\_\_\_\_
* OXYGEN ADMINISTERED\_\_\_\_\_
* TAKEN TO MEDICAL FACILITY \_\_\_\_\_\_
* VISUAL TESTING\_\_\_\_\_
* OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL TREATMENT RECEIVED?** YES\_\_\_\_\_\_ NO \_\_\_\_\_\_

**HOSPITAL** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TIME AND DATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIBED TREATMENT**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF THE** **CLASS MEDIC (IF APPLICABLE)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PRINTED NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INJURED PARTY DEPARTMENT INFORMATION**

**DEPARTMENT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FAX NUMBER** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE AND TIME DEPARTMENT NOTIFIED**: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**PERSON NOTIFIED**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF THE** **INJURED PARTY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PRINTED NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF THE** **CADRE/STAFF** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PRINTED NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_