Clear

WASHINGTON VOLUNTEER FIREFIGHTERS' & RESERVE OFFICERS'
RELIEF AND PENSION FUND

REPORT OF ACCIDENT

REPORT OF INJURED MEMBER

Name of department _____ Date of Accident _____

Name of injured member _____ Birthdate _____ M ☐ F ☐

Address of member _____ Phone #_____
Mailing Address City State Zip code

Regular occupation _____ Social Security Number _____

Single ☐ Married ☐ Full Name of Spouse _____

Children under 18 supported by you:
Name: _____ Birthdate: _____ Name: _____ Birthdate: _____

Name: _____ Birthdate: _____ Name: _____ Birthdate: _____

Activity at the time of the accident:

☐ Responding to:	☐ At scene:	☐ Returning from:	☐ Training:	☐ Other activity:
☐ aid call	☐ aid call	☐ aid call	☐ at academy	_____
☐ fire	☐ fire	☐ fire	☐ at station	_____
☐ patrol	☐ patrol	☐ patrol	☐ at live fire	_____
☐ other _____	☐ other _____	☐ other _____	☐ other _____	_____
_____	_____	_____	_____	_____

Describe the accident in full: _____

_____

_____

_____

I hereby authorize any hospital, physician or other person who has attended me or examined me to furnish to Board for Volunteer Firefighters and Reserve Officers any and all information with respect to any accident or illness, medical history, consultation, prescriptions or treatment, and copies of hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Witness to accident: **X** _____ **SIGN HERE X**_____ Date**:** _____
(Injured member sign in ink)

REPORT OF CHIEF OR SHERIFF

Name of chief or sheriff _____ Officer in charge _____

How can such injuries be prevented? _____

Did member lose time from regular work? Yes ☐ No ☐ Hospitalized? Yes ☐ No ☐

Date of accident _____ Time of accident _____ Location of accident _____

Has the injured been registered as required by the Volunteer Firefighters' & Reserve Officers' Relief Act? Yes ☐ No ☐
Did the injury occur as a result of a mobilization? Yes ☐ No ☐

X_____ **X**_____
(Signature of Chief or Sheriff) (Signature of officer in charge)

REPORT OF PHYSICIAN

Date physician called _____ Time physician called _____

Describe in full the extent of injury _____

_____

_____

Is there any pre-existing impairment to the injured area or has patient been treated for the same or similar condition? ☐ Yes ☐ No

Estimate time loss, if any _____ **X** _____
(Signature of attending physician)

REPORT OF LOCAL BOARD OF TRUSTEES

Date claim filed _____ Date of hearing by local board _____

Date claim granted _____ Date claim rejected _____

X _____ **X** _____
(Chair of local board) (Secretary of Local Board)

Please keep a copy of this form for your records and send the original to BVFF, PO Box 114, Olympia, WA 98507.