







Johnson County Fire Protection District Near-Miss Incident Report

Employee's Name (Last, First, MI)		DOB	
Address	Sex	Job Title	
	M F	Assigned Station/Division	
Phone Number () Home ___ Cell ___		Years of Service 0-1 ___ 1-3 ___ 3-5 ___ 5-10 ___ 10+ ___ UNK ___	
Activity being performed at time of near-miss:	PPE Required Yes ___ No ___	PPE Worn Yes ___ No ___	Was an Injury Report Completed? Yes ___ No ___
Circle Area(s) affected by the incident: ___None ___ Other		PPE worn at time of incident: (Check all that apply) <input type="checkbox"/> Helmet <input type="checkbox"/> Helmet Shield In Use <input type="checkbox"/> Hood <input type="checkbox"/> Bunker Coat <input type="checkbox"/> Bunker Gloves <input type="checkbox"/> Bunker Pants <input type="checkbox"/> Bunker Boots <input type="checkbox"/> SCBA (Breathing Air) <input type="checkbox"/> Gloves Other <input type="checkbox"/> Boots Other <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Hearing Protection <input type="checkbox"/> Other _____	
   		Location Incident Occurred: Address: Type of event: <input type="checkbox"/> Incident- Run # ___ - ___ <input type="checkbox"/> Training <input type="checkbox"/> Other: _____	

COMPLETE BOTH SIDES OF FORM



Johnson County Fire Protection District Near-Miss Incident Report

Description of Incident (Attach Additional Pages if Necessary):

Recommendation for prevention of re-occurrence:

Was medical treatment offered? Yes ___ No ___ Was medical treatment refused? Yes ___ No ___

Date of refusal: _____

I am declining my employer's offer of authorized medical treatment to cure and relieve the effects of the near-miss incident I am claiming to have sustained at work on the date listed above. I understand that by declining my employer's offer of medical care, any treatment I obtain on my own will be at my own expense. I also understand that if I reconsider and am interested in receiving authorized medical care, I must advise my employer as soon as possible.

Signature of employee refusing medical treatment: _____ Date: _____

Witness (Name and Phone)

Witness (Name and Phone)

Return completed form to HQ immediately or contact the Administrative office at 660-747-5220 to have form picked up from station.

Signature of Person Completing Form: _____ Date: _____

ADMINISTRATIVE USE ONLY:

Received on ___/___/___ By _____ Provided to TSD: ___/___/___ Received By: _____

Investigator Signature: _____ Division Chief: _____

COMPLETE BOTH SIDES OF FORM