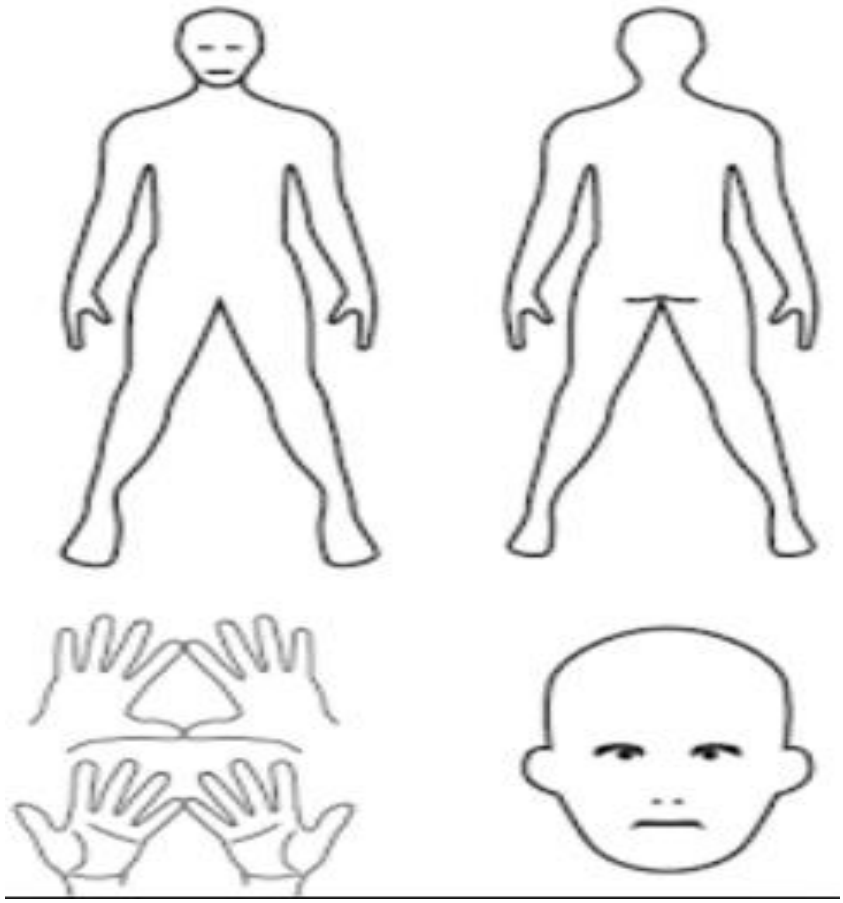
Johnson County Fire Protection District
Near-Miss Incident Report

Employee's Name (Last, First, MI)			**DOB**
Address	**Sex** M F	**Job Title** **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)

- __Helmet
- __Helmet Shield In Use
- __Hood
- __Bunker Coat
- __Bunker Gloves
- __Bunker Pants
- __Bunker Boots
- __SCBA (Breathing Air)
- __Gloves Other
- __Boots Other
- __Safety Glasses
- __Hearing Protection
- __Other _____

Location Incident Occurred:

Address:

Time of incident:

Date of incident:

Type of event:

- __Incident- Run #___-_____
- __Training
- __Other: _____

COMPLETE BOTH SIDES OF FORM

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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.

Printed Name of Person Completing Form:_____ Date:_____

Signature of Person Completing Form:_____ Date:_____

ADMINSTRATIVE USE ONLY:

Received on ____/_____/____By_____ Provided to TSD: _____/_____/_____ Received By:_____

Investigator Signature:_____ Division Chief:_____

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