



**KING OF PRUSSIA VOLUNTEER FIRE COMPANY**  
**170 ALLENDALE ROAD**  
**KING OF PRUSSIA, PENNSYLVANIA 19406**  
610-265-1063 Allendale Road Station  
610-337-8230 West Beidler Road Station  
610-265-3205 FAX  
610-265-5635 Social Hall  
email [kpvfc@pond.com](mailto:kpvfc@pond.com)  
Web [www.kpvfc.com](http://www.kpvfc.com)

### Standard Operating Guidelines

**SOG NO.:** KP-1-0016  
**SOG TITLE:** REPORTING FIREFIGHTER INJURIES  
**ADOPTION DATE:** 01/92  
**REVISION DATE:** 01/05  
**NO. OF PAGES:** 5

**Purpose:** To establish procedures for reporting firefighter injuries.

If a Firefighter is injured at the scene of a fire, training event, fire prevention activity, performing apparatus maintenance and /or facility maintenance, the Officer in Charge, Fire Chief, and Safety Officer shall be notified immediately. The following information shall be provided:

1. Name(s) of injured.
2. Extent of injuries.
3. Location at fire scene.
4. If transport to hospital is needed.

Unless it is a life-threatening situation, no injured Firefighter(s) should be moved, or allowed to move, until checked by qualified medical personnel.

If it is deemed by a qualified medical authority that the injured party needs further medical attention, the injured party will be transported to a hospital for medical treatment. In the hospital, all information regarding responsibility for payment should be:

**Upper Merion Township**  
**175 West Valley Forge Road**  
**King of Prussia, PA 19406**  
**Telephone No.: 610-265-2600**

Within 48 hours of the incident, the firefighter or the Officer in Charge of the activity shall complete an Injury Report. The report shall be handed to the Safety Officer and copied to the Fire Chief.

The Safety Officer shall forward the Injury Report to the Township for processing and place a copy of the report in the firefighter's personnel file.

(See Attachment.)

**UPPER MERION TOWNSHIP**  
**Incident Report**

<p><b>NAME</b> _____</p> <p><b>ADDRESS</b>          _____          _____          _____          _____          (street, city, zip)</p> <p><b>TELEPHONE</b>          _____  <small>area code                  number</small></p> <p><b>SUPERVISOR NOTIFIED</b>          _____  <small>name                          date</small></p> <p><b>SOCIAL SECURITY#</b> _____</p>	<p><b>JOB TITLE</b> _____  <small>if employee incident</small></p> <p><b>DATE OF INCIDENT</b>          _____</p> <p><b>TIME OF INCIDENT</b>          _____</p> <p><b>STARTING TIME</b>          _____</p> <p><b>TYPE</b>          _____  <small>employee                          visitor</small></p> <p><b>INJURIES?</b>          _____  <small>yes                                  no</small></p> <p><b>LOST TIME?</b>          _____  <small>yes                                  no</small></p> <p><input type="checkbox"/> <i>Check here if this could result in an insurance claim</i></p>
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**EXACT LOCATION OF INCIDENT:**

**DESCRIPTION OF THE INCIDENT: (who, what, when, where, why, how)**

**CAUSES OR CONTRIBUTING FACTORS:**

**RECOMMENDATIONS:**

**ACTION TAKEN:**

Penn Services Testing

**WITNESSES OR PEOPLE FAMILIAR WITH THE INCIDENT:**

name	address
_____	_____
_____	_____
_____	_____
_____	_____



**IF INJURIES INVOLVED, DESCRIPTION OF INJURIES & WHERE TREATMENT WAS SOUGHT:**

If injured party is employee of Upper Merion, please provide:

Date of birth: \_\_\_\_\_ Date of hire: \_\_\_\_\_

Married?  yes  no # of dependents: \_\_\_\_\_



\_\_\_\_\_  
signature of person filling out report

\_\_\_\_\_  
address

\_\_\_\_\_  
date

\_\_\_\_\_

phone

**copies to:**

**department head**

**Vicchio**

**Wagenmann**

**Wert**

**Waters**

**Santoro**

**email: [lrsubmit@umtownship.org](mailto:lrsubmit@umtownship.org)**

signature of department supervisor
signature of department head

**revised: 14-Jul-04**