

VESSEL ACCIDENT REPORT 1.1

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|---------------------------|-------------|---------------|
| DATE OF ORIGINAL ACCIDENT | TIME (2400) | REPORT NUMBER |
| DEPUTY NAME | | DEPUTY ID |

| VICTIM / WITNESS NAME, ADDRESS & PHONE | VICTIM / WITNESS STATUS | RIDING IN VESSEL # | DOB/ AGE | INJURY DESCRIPTION | LIFE JACKET WORN? | COULD VICTIM SWIM? |
|---|---|-----------------------|-------------|---|---|---|
| | <input type="checkbox"/> INJURED <input type="checkbox"/> DECEASED <input type="checkbox"/> DISAPPEARED <input type="checkbox"/> PASSENGER ONLY <input type="checkbox"/> WITNESS ONLY | | | _____ TAKEN TO HOSPITAL <input type="checkbox"/> YES <input type="checkbox"/> NO FACILITY _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN |
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