

VESSEL ACCIDENT REPORT 1.1

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
	<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
	<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
	<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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