

CONFIDENTIAL	
FOR STATE USE ONLY	
Case Number	Date
County	

## FATAL/SERIOUS ACCIDENT REPORT

1. Date of Incident ____ / ____ / ____ <i>Month Day Year</i>	2. Time of Incident ____ : ____ <input type="checkbox"/> AM <input type="checkbox"/> PM	3. Date of Report ____ / ____ / ____ <i>Month Day Year</i>
4. Activity of Victim ( <i>Check ALL that apply</i> )		
1 <input type="checkbox"/> Swimming (SW) 2 <input type="checkbox"/> Bathing (Hot Tub) (BH) 3 <input type="checkbox"/> Wading (WD) 4 <input type="checkbox"/> Surfing (SF) 5 <input type="checkbox"/> Skiing (SK) 6 <input type="checkbox"/> SCUBA/Snorkeling (SC) 7 <input type="checkbox"/> Playing by Water (PW) 8 <input type="checkbox"/> Diving (DV)	9 <input type="checkbox"/> Using Swimming Accessories, Inflatable (SI) 10 <input type="checkbox"/> Using Swimming Accessories, Other (SO) 11 <input type="checkbox"/> Fell into Water (FW) 12 <input type="checkbox"/> Fell Elsewhere (FE) 13 <input type="checkbox"/> Attempting Rescue, Lifeguard (LG) 14 <input type="checkbox"/> Attempting Rescue, Other (AR) 15 <input type="checkbox"/> Boating (BT) 16 <input type="checkbox"/> Other (OT) _____	
<b>VICTIM INFORMATION</b>		
5. Victim ID <b>VICTIM #</b>		6. Age of Victim
7. Sex 1 <input type="checkbox"/> Male    2 <input type="checkbox"/> Female 3 <input type="checkbox"/> Other/Unknown	8. Race 1 <input type="checkbox"/> White    3 <input type="checkbox"/> Hispanic 2 <input type="checkbox"/> Black    4 <input type="checkbox"/> Other	9. Height ____ <i>Feet Inches</i>
		10. Weight ____ <i>Pounds</i>
11. Physical Condition/Limitations		
1 <input type="checkbox"/> Intoxicated/Alcohol Consumed a. Tested?    1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Unknown b. Time Done? _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM c. Blood Level? _____		3 <input type="checkbox"/> Heart Disease 4 <input type="checkbox"/> Epilepsy 5 <input type="checkbox"/> Deafness 6 <input type="checkbox"/> Blindness 7 <input type="checkbox"/> Extreme Overweight 8 <input type="checkbox"/> Other
2 <input type="checkbox"/> Drugs or Narcotics Used a. Tested?    1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Unknown b. Time Done? _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM c. Blood Level? _____		_____
<b>EXACT LOCATION</b>		
12. Name of Facility or Body of Water		13. County
14. Street Address		
15. City, State, Zip Code		16. Site (Landmarks, Guard Tower Numbers, etc.)
17. Body of Water		
1 <input type="checkbox"/> Ocean 2 <input type="checkbox"/> Bay 3 <input type="checkbox"/> Lake	4 <input type="checkbox"/> Pond/Pit 5 <input type="checkbox"/> Ditch/Canal 6 <input type="checkbox"/> River/Creek/Stream	7 <input type="checkbox"/> Swimming and Wading Pool 8 <input type="checkbox"/> Hot Tub/Spa 9 <input type="checkbox"/> Other _____

**FATAL/SERIOUS ACCIDENT REPORT  
(Continued)**

<b>INCIDENT INFORMATION</b>		
18. Was there immersion by the victim into water involved? 1 <input type="checkbox"/> Yes, Entry Voluntary 2 <input type="checkbox"/> Yes, Entry Involuntary 3 <input type="checkbox"/> Yes, Unknown Whether Voluntary or Involuntary 4 <input type="checkbox"/> Incident Did Not Involve Immersion	a. If Yes, what was the victim's swimming ability? 1 <input type="checkbox"/> Good      2 <input type="checkbox"/> Fair      3 <input type="checkbox"/> Poor      4 <input type="checkbox"/> Unknown	
	b. If the victim is a minor, was a "Supervisor" present? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	
	c. Was a personal flotation device worn? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	
	d. What was the water depth?  <div style="display: flex; justify-content: space-around; width: 100%;"> <span>_____ Feet</span> <span>_____ Inches</span> </div>	e. What was the bather load at the time of accident?
19. What were the Weather/Water conditions? <b>(FOR ALL RECREATIONAL BATHING FACILITIES)</b> a. Air Temperature: _____ Degrees Fahrenheit b. Water Temperature: _____ Degrees Fahrenheit c. Did Water/Weather conditions contribute? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No <b>(FOR POOLS AND HOT TUBS ONLY)</b> d. Was Water Cloudy? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No <b>(FOR BATHING BEACHES ONLY)</b> e. Wind: 1 <input type="checkbox"/> None      2 <input type="checkbox"/> Light      3 <input type="checkbox"/> Moderate      4 <input type="checkbox"/> Strong f. Wind Direction: 1 <input type="checkbox"/> From Shore      2 <input type="checkbox"/> From Water      3 <input type="checkbox"/> Along Shore g. Rip tide current involved (ocean only) 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No h. Longshore current? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No		
20. Was it a public recreational bathing place? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	a. If Yes, was the facility licensed/approved? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	
21. Was it a specially exempt facility? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	a. If Yes, were there signs ("No lifeguard on duty", "Persons under the age of 16 must be accompanied by an adult", "No swimming alone") prominently displayed at the entrance of the swimming area? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	
22. Did the incident occur in a guarded area? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	23. Were other people around? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	24. Was there video surveillance? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No
25. Was the facility open for public use at the time? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	a. If Yes, was a lifeguard on duty? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	
26. Was there any violation of NJAC 8:26 "Public Recreational Bathing" regulation that may have contributed to the incident? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No If Yes, list citation numbers and describe: _____		
<b>MEDICAL ATTENTION</b>		
27. What kind of incident occurred at the scene? 1 <input type="checkbox"/> Drowning      3 <input type="checkbox"/> Suspected Neck Injury and Central Nervous System Trauma 2 <input type="checkbox"/> Near Drowning      4 <input type="checkbox"/> Other: _____		
28. Was the victim unconscious at any time? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No		
29. Was medical attention given? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	a. If Yes, by whom?	
30. Was CPR administered? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	a. If Yes, by whom?	
31. Were emergency medical services called? 1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No	a. If Yes, type of provider? 1 <input type="checkbox"/> Doctor      2 <input type="checkbox"/> Ambulance 3 <input type="checkbox"/> Other:	

**FATAL/SERIOUS ACCIDENT REPORT  
(Continued)**

30. What was the outcome of medical attention? 1 <input type="checkbox"/> Treated at Scene and Released 2 <input type="checkbox"/> Victim Transferred to Medical Care 3 <input type="checkbox"/> Victim Refused Medical Care 4 <input type="checkbox"/> Dead at Scene 5 <input type="checkbox"/> Other:	a. If the victim was transferred to medical care, give name of facility:
	b. Was the victim admitted to a hospital? 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Unknown

31. Did the victim die as a result of this accident?  
 1  Yes    2  No    3  Unknown

32. Was the local health department notified by the owner/operator?  
 1  Yes    2  No

a. If Yes, when? \_\_\_\_\_

b. If Yes, by whom? \_\_\_\_\_

c. If No, how did the local health department become aware? \_\_\_\_\_

**DESCRIPTION OF INCIDENT**

Describe incident, including all pertinent information. Elaborate as necessary. Also describe any measures that might prevent a future incident of this nature. Use additional continuation sheets if necessary.

Name of Health Official Completing Form (Print)	Title
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Signature	Date
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Distribution: Original - NJDOH  
Copy - Local Health Department