

**VOLUNTEER FIREFIGHTERS' BENEFIT ASSOCIATION
FIRST REPORT OF INJURY**

Date: _____

Firefighter Name _____

Home Address _____ City _____ State _____ ZIP _____

Phone – Home _____ Cell _____

Fire Department _____ VFBA Certificate No. _____ VOL _____ PAID _____

INCIDENT INFORMATION

Incident Address _____

Date ___/___/___ City _____ County _____ State _____ Hour _____ AM _____ PM _____

Describe Injury Incident in Detail _____

Injured Part of Body _____

Name/Address of Attending Physician _____

Name/Address of Medical Facility _____

Regular Occupation _____

Name of 2 Witnesses _____

District # _____ Director Name _____

Signature Chief/Acting Chief _____ Phone # _____

Fire Dept Address _____ City _____ State _____ Zip _____

Phone – Office _____

Send finished report to Secretary of VFBA within 30 days of injury incident.

**Send to: Bruce Boynton, Secretary
 VFBA of MN
 P.O. Box 71
 Lewiston, MN 55952
 Phone - **507-523-3614****