

This report must be submitted within 24 hours for any transportation event whether or not an injury occurs.

This includes, but is not limited to, an incident involving loading or unloading, a fall, auto accident, device securement issue, harsh braking, member conduct/misconduct, or an action requiring a driver to take a defensive measure during transport. The form should also be used to report any work-related incident involving a Modivcare employee. **Please note**: An incident often serves as a basis for a future lawsuit. You may have a duty to preserve records and other potential evidence related to this incident, including but not limited to, communications, emails, photographs, videos, electronic files, and paper or other hard copy documents. Please be advised that if this incident becomes a lawsuit, the destruction or loss of any potentially relevant information related to this incident – even if inadvertent – could subject your company to significant court sanctions.

Section I – Member Information

Member Name:	Trip #:
Member Address:	Member Phone #:
City, State, Zip:	Member Age:

Section II – Transportation Provider (TP) & Driver Information

TP Name/Company Name:	Driver's Name:	
TP Address and Phone #:	Driver Phone #:	
Time Driver Began Shift: AM / PM	# of Trips Completed Prior to Incident for the Day:	
Vehicle Make/Model:	Vehicle License Plate #:	
VIN #:	Insurer Name & Phone #:	
Driver CTAA/PASS Trained: Yes or No (Circle 1) Vehicle Camera: Yes or No (Circle 1)	Description of Other Driver Training: Date of Training(s):	

Section III – Trip Information

Incident Date:// Incident Time: AM / PM	Location of Incident:
Reported to Modivcare Date:// Time: AM / PM	Description of Weather and Road Conditions (please describe):
Modivcare Trip #:	
Pick-up Location:	Drop-off Location:
On-time Pickup? Yes or No (Circle One)	On-time Drop-off? Yes or No (Circle One)
Multi-loaded trip: Yes or No (Circle One)	Attendant or Escort Present: Yes or No (Circle One)
Service Animal Present: Yes or No (Circle One)	Assistive Mobility Device: Yes or No (Circle One) Describe Device:



Modivcare Member Incident / Accident / Injury Report

Driver Injury

Driver Backing

□ Wheelchair securement □ Slip/Trip/Fall in Vehicle

□ Service Animal Injury

□ Injury to Member of Public

Section IV: Nature of Incident (Please check all that apply):

Loading Member	Unloading Member	
Scooter Securement	Other Mobility Device Securement	
□ Slip/Trip/Fall Outside Vehicle	Exiting Facility or Residence	
Attendant Injury	Member Conduct/Misconduct	
Struck by Other Vehicle	Driver Struck Other Vehicle	
Harsh Braking	Damage to Property	
	-	

□ Other (please describe)_____

Section V: Injury Description

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Please describe the injury to men	nber, driver, escort, and/or service animal:	
If "Member Conduct/Misconduct"	is marked please explain:	
Was the member asked if they wa	ant to seek medical treatment? Yes or No ((Circle One)
If Yes, how & where was passeng	ger transported? (Please specify)	
Witness Information (including es	 corts & other riders): Please include contac	t information for any witness(es) and
use additional pages as needed.		
Name:	Address:	
	Email:	
Law Enforcement Called: Yes or N	No (Circle One)	
If Yes, Identify Law Enforcement A		
	e statement by the driver below as requir	red by transportation provider
agreement.		
Electronic Signature of Driver: s/_		
Section VI: Post Incident/Injury/A	ccident Action	
Injury – Continue to ER	Injury – Continue to Appointment	Injury – Continue/return to home
	□ No Injury – Continue/Return to home	
Person receiving member (either	at facility or residence), if applicable:	
Name:	Title:	

Contact Phone Number: ______ Email: _____



Modivcare Member Incident / Accident / Injury Report

Time: AM / PM (Circle One)		
Was the person receiving the member advised of the incident? Yes or No (Circle One)		
Member's Acceptance of Medical Treatment Action <u>OR</u> Member's Refusal of Medical Treatment.		
NOTE: If acting on the member's behalf, please include name, date and signature of person/representative completing this form.		
Member Accepted Medical Treatment: Yes or No (Circle One)		
Date: Time: AM / PM (Circle One) Member Name/Representative (please print):		
Member/Representative Signature:		

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