INCIDENT REPORT FORM

Date and Time of Incident/ Event: _____

Name of Person completing form: _____

Position/Title: _____

Contact Address: _____

Phone Number: _____

Location of Event (Address /Details): _____

_____

Are any person/ party effected? ☐ No ☐ Staff ☐ Student ☐ Other

Name of injured/ affected person: _____

Contact Address: _____

Phone Number: _____

Date of birth: _____ ☐ Male ☐ Female

(If more than 1 person affected, please attach additional details)

Type of Incident:

☐ Injury ☐ Property Damage ☐ Security Breach

☐ Environmental Incident ☐ Hazard ☐ Others, specify:

Details of Incident: _____

_____

_____

Actions Taken : _____

_____

_____

_____

_____

_____

Follow-Up Actions Recommended: _____

_____

_____

_____

_____

_____

Return this form to Admin within 24 hours of Event

Injury requires **immediate** physician/hospital treatment? ☐ Yes ☐ No

Name of Physician/Hospital: _____

Address: _____

Physician/hospital phone number: _____

(Please remember to obtain a medical certificate from treating Physician)

_____ _____

Signature of person completing form Date

Management Section

Risk Rating: ☐ Low ☐ Medium ☐ High

Requires further enquiry ☐ Yes ☐ No

Certificate from the Treating physician ☐ Yes ☐ No

Staff Time off required ☐ Yes ☐ No

Start: _____ Expected return: _____ Total Expected Days off _____

Controls and Actions Taken: _____

_____

_____

_____

_____

_____

_____

Resolved ☐ Yes ☐ No

Management Section Completed by:

Name: _____ Position: _____

Signature: _____ Date: _____

Please scan and file original document