UNIVERSITY, COLLEGE AND INSTITUTE PROTECTION PROGRAM
RISK MANAGEMENT
P.O. Box 3586
Victoria, British Columbia
V8W 3W6

Phone No.: (250) 387-0525
Fax No.: (250) 953-3050

INCIDENT REPORT

Please type or print in block letters. Attach an additional sheet if more space is required.

1 GENERAL

This section MUST be completed in full

NAME OF INSTITUTION/FACILITY | LOCATION | PHONE NO. ( )

NAME OF INSTRUCTOR INVOLVED | DATE OF INCIDENT YYYY MM DD | TIME OF INCIDENT: : a.m. p.m

DESCRIPTION OF HOW INCIDENT OCCURRED

WITNESSES – *If more than 2 witnesses, attach an additional sheet.*

1. NAME OF WITNESS

ACTIVITY OF WITNESS AT TIME OF INCIDENT

2. NAME OF WITNESS

ACTIVITY OF WITNESS AT TIME OF INCIDENT

THERE WERE NO WITNESSES TO THE INCIDENT

LOCATION OF INCIDENT:

01	BASEMENT	12	PLAYING FIELDS
02	CAFETERIA/LUNCHROOM	13	PLAYGROUND EQUIPMENT
03	CLASSROOM	14	POOL
04	SHOPS/LABS/KITCHENS	15	RINK
05	DOORS/ENTRANCE AREAS	16	SIDEWALKS/ROADS OFF FACILITY PROPERTY
06	DORMITORIES	17	STAIRS WITHIN BUILDING
07	GYMNASIUM/AUDITORIUM	18	STAIRS/SIDEWALKS WITHIN GROUNDS
08	HALLWAY/LOCKERS	19	WASHROOMS/CHANGING ROOMS/SHOWERS
09	LIBRARY/OFFICE/ LOUNGE/STUDY ROOM	20	OTHER – *Please explain:*
10	PARK/GROUNDS		
11	PARKING LOT		

2 A

Complete this section for Bodily Injury/ Other Party Damage

NAME OF PERSON INVOLVED IN INCIDENT | AGE | GENDER – For statistical purposes only ___ MALE ___ FEMALE | PROGRAM | NIGHT SCHOOL YES NO

HOME ADDRESS / CITY / PROVINCE | POSTAL CODE

STATUS
STUDENT VISITOR OTHER – *Please explain:*

EMERGENCY CONTACT NAME | WAS THE CONTACT PERSON NOTIFIED? YES NO *If YES, please explain how:*

INSTRUCTIONS/COMMENTS OF EMERGENCY CONTACT

FIRST AID TREATMENT REQUIRED? YES NO | TYPE OF TREATMENT PROVIDED? | BY WHOM? | ADVISED TO SEEK MEDICAL TREATMENT? YES NO

WAS HOSPITAL CARE PROVIDED? YES NO *If YES, please identify type of care:* ADMITTED EMERGENCY VISIT ONLY | TREATMENT? *(If known)* | HOW WAS THE PATIENT TRANSPORTED? AMBULANCE PRIVATE VEHICLE OTHER:

NATURE OF INJURY/DAMAGE – ***Check one only***

01	BRUISE/ABRASION/SWELLING	11	NOSEBLEED
02	BURN	12	OPEN WOUND/LACERATION
03	CONCUSSION(SUSPECTED)	13	SPRAIN/STRAIN (SUSPECTED)
04	CRUSHED	14	WINDED
05	DENTAL DAMAGE	15	PROPERTY DMG./OTHER PARTY
06	DISLOCATION	16	OTHER – *Please explain:*
08	FRACTURE		
09	IMBEDDED OBJECT		
10	NO INFORMATION	07	FATALITY/DEATH

BODY AREA INJURED – ***Check one only***

01	ARMS/SHOULDER/ELBOW	09	MULTIPLE AREAS
02	CHEST/ABDOMEN/PELVIS	10	NECK
03	EYES	11	NO INFORMATION
04	FACE	12	SPINE/BACK
05	FEET/TOES	13	TEETH/MOUTH
06	FINGERS/HANDS/WRISTS	14	OTHER – *Please explain:*
07	HEAD/FOREHEAD		
08	LEGS/KNEES/ANKLES		

CAUSE OF INJURY OR DAMAGE – ***Check one only***

*01	ASSAULT-NO WEAPON (INTENTIONAL)	11	MAINTENANCE ACTIVITY
*02	ASSAULT-WITH WEAPON (INTENTIONAL)	12	MOTOR VEHICLE ACCIDENT
03	CHOKING/SUFFOCATION	13	POISONING/ALLERGIC REACTION/INSECT BITE
04	DROWNING		
05	EXPOSURE TO FLAME/ELECTRICITY/ HOT OR CAUSTIC SUBSTANCE	14	BUS ACCIDENT
		15	SPORTS INJURY
		16	STRUCK AGAINST PERSON
06	FALL AT SAME HEIGHT	17	STRUCK/CRUSHED BY/ AGAINST OBJECT
07	FALL FROM DIFFERENT HEIGHT		
08	FATIGUE/OVER EXERTION	18	OTHER – *Please explain:*
09	FOREIGN BODY		
*10	HORSEPLAY (NO INTENT TO INJURE)	*19	SEXUAL ASSAULT (ALLEGATIONS INCLUDED)

*List names of others involved:

ACTIVITY AT TIME OF INCIDENT – ***Check one only***

01	CLASSROOM	08	TRAVEL TO OR FROM FACILITY
02	BETWEEN CLASSES	09	UNORGANIZED SPORTS
03	EXTRA-CURRICULAR (i.e. CLUB)	10	WORK PLACEMENT
04	OUT-OF-CLASS FIELD TRIP	11	MAINTENANCE ACTIVITY
05	PRE-OR POST CLASS	12	OTHER – *Please explain:*
06	SPORTS EVENT		
07	SPORTS RELATED CLASS		

2 B

Complete this section for Loss or Damage to Facility and/or Contents

PROPERTY INVOLVED – *Describe property Involved. Attach addtional sheet if more space is required.* | ESTIMATE OF LOSS/DAMAGE $

PROPERTY INVOLVED IS:
___ OWNED ___ LEASED ___ PERSONAL

DID THE FIRE DEPARTMENT ATTEND? ___ YES ___ NO | REPORT NUMBER

WERE POLICE NOTIFIED? ___ YES ___ NO | NAME OF BRANCH/DETACHMENT | CASE NUMBER

WERE THERE VISIBLE SIGNS OF FORCED ENTRY?
___ YES ___ NO *If YES, please explain:*

CAUSE OF LOSS/DAMAGE

01	BURGLARY/FORCIBLE ENTRY	10	ROBBERY
02	COLLAPSE	11	SMOKE
03	DISHONESTY/INFIDELITY	12	THEFT
04	EXPLOSION	13	TRANSPORTATION
05	FALLING OBJECT	14	VANDALISM/ MALICIOUS ACTS
06	FIRE/LIGHTNING		
07	GLASS BREAKAGE	15	WATER/ESCAPE
08	IMPACT BY VEHICLE/ AIRCRAFT		RUPTURE/FREEZING
		16	WINDSTORM/HAIL
09	RIOT	17	OTHER – *Please Explain:*

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FULL NAME OF PERSON COMPLETING REPORT – *Please print* | TITLE | SIGNATURE | DATE SIGNED YYYY MM DD

FULL NAME OF ADMINISTRATOR – *Please print* | SIGNATURE | DATE SIGNED YYYY MM DD

OTHER INFORMATION/COMMENTS/UPDATE?

WORK SAFE BC

First Aid Record

This record must be kept by the employer for three (3) years. This form must be kept at the employer's workplace. Do **NOT** submit to WorkSafeBC.

Sequence number

Name	Occupation
Date of injury or illness (yyyy-mm-dd)	Time of injury or illness (hh:mm) a.m. p.m.
Initial reporting date and time (yyyy-mm-dd) (hh:mm) a.m. p.m.	Follow-up report date and time (yyyy-mm-dd) (hh:mm) ☐ a.m. ☐ p.m.
Initial report sequence number	Subsequent report sequence number(s)

Description of how the injury, exposure, or illness occurred (What happened?)

Description of the nature of the injury, exposure, or illness (What you see — signs and symptoms)

Description of the treatment given (What did you do?)

Name of witnesses

1.	2.

Arrangement made relating to the worker (return to work/medical aid/ambulance/follow-up)

Provided worker handout ☐ Yes ☐ No Alternate duty options were discussed ☐ Yes ☐ No	A form to assist in return to work and follow-up was sent with the worker to medical aid Yes No
First aid attendant's name (please print)	First aid attendant's signature
Patient's signature	