



# INCIDENT REPORT

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

<b>1</b>	NAME OF INSTITUTION/FACILITY	LOCATION	PHONE NO. ( )	
	NAME OF INSTRUCTOR INVOLVED	DATE OF INCIDENT YYYY MM DD	TIME OF INCIDENT: : : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
	DESCRIPTION OF HOW INCIDENT OCCURRED			
<b>GENERAL</b>	WITNESSES - <i>If more than 2 witnesses, attach an additional sheet.</i>		LOCATION OF INCIDENT:	
	1. NAME OF WITNESS	ACTIVITY OF WITNESS AT TIME OF INCIDENT	01 <input type="checkbox"/> BASEMENT 02 <input type="checkbox"/> CAFETERIA/LUNCHROOM 03 <input type="checkbox"/> CLASSROOM 04 <input type="checkbox"/> SHOPS/LABS/KITCHENS 05 <input type="checkbox"/> DOORS/ENTRANCE AREAS 06 <input type="checkbox"/> DORMITORIES 07 <input type="checkbox"/> GYMNASIUM/AUDITORIUM 08 <input type="checkbox"/> HALLWAY/LOCKERS 09 <input type="checkbox"/> LIBRARY/OFFICE/ LOUNGE/STUDY ROOM 10 <input type="checkbox"/> PARK/GROUNDS 11 <input type="checkbox"/> PARKING LOT	12 <input type="checkbox"/> PLAYING FIELDS 13 <input type="checkbox"/> PLAYGROUND EQUIPMENT 14 <input type="checkbox"/> POOL 15 <input type="checkbox"/> RINK 16 <input type="checkbox"/> SIDEWALKS/ROADS OFF FACILITY PROPERTY 17 <input type="checkbox"/> STAIRS WITHIN BUILDING 18 <input type="checkbox"/> STAIRS/SIDEWALKS WITHIN GROUNDS 19 <input type="checkbox"/> WASHROOMS/CHANGING ROOMS/SHOWERS 20 <input type="checkbox"/> OTHER - <i>Please explain:</i>
	2. NAME OF WITNESS	ACTIVITY OF WITNESS AT TIME OF INCIDENT		
	<input type="checkbox"/> THERE WERE NO WITNESSES TO THE INCIDENT			
<b>2 A</b>	NAME OF PERSON INVOLVED IN INCIDENT		AGE	
	HOME ADDRESS / CITY / PROVINCE		POSTAL CODE	
	STATUS <input type="checkbox"/> STUDENT <input type="checkbox"/> VISITOR <input type="checkbox"/> OTHER - <i>Please explain:</i>			
	EMERGENCY CONTACT NAME		WAS THE CONTACT PERSON NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If YES, please explain how:</i>	
	INSTRUCTIONS/COMMENTS OF EMERGENCY CONTACT			
	FIRST AID TREATMENT REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF TREATMENT PROVIDED?	BY WHOM?	
	WAS HOSPITAL CARE PROVIDED? <i>If YES, please identify type of care:</i>		HOW WAS THE PATIENT TRANSPORTED?	
	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ADMITTED <input type="checkbox"/> EMERGENCY VISIT ONLY		<input type="checkbox"/> AMBULANCE <input type="checkbox"/> OTHER: PRIVATE VEHICLE	
	NATURE OF INJURY/DAMAGE - <i>Check one only</i>		BODY AREA INJURED - <i>Check one only</i>	
	01 <input type="checkbox"/> BRUISE/ABRASION/SWELLING 02 <input type="checkbox"/> BURN 03 <input type="checkbox"/> CONCUSSION(SUSPECTED) 04 <input type="checkbox"/> CRUSHED 05 <input type="checkbox"/> DENTAL DAMAGE 06 <input type="checkbox"/> DISLOCATION 08 <input type="checkbox"/> FRACTURE 09 <input type="checkbox"/> IMBEDDED OBJECT 10 <input type="checkbox"/> NO INFORMATION 11 <input type="checkbox"/> NOSEBLEED 12 <input type="checkbox"/> OPEN WOUND/LACERATION 13 <input type="checkbox"/> SPRAIN/STRAIN (SUSPECTED) 14 <input type="checkbox"/> WINDED 15 <input type="checkbox"/> PROPERTY DMG./OTHER PARTY 16 <input type="checkbox"/> OTHER - <i>Please explain:</i> OR <input type="checkbox"/> FATALITY/DEATH		01 <input type="checkbox"/> ARMS/SHOULDER/ELBOW 02 <input type="checkbox"/> CHEST/ABDOMEN/PELVIS 03 <input type="checkbox"/> EYES 04 <input type="checkbox"/> FACE 05 <input type="checkbox"/> FEET/TOES 06 <input type="checkbox"/> FINGERS/HANDS/WRISTS 07 <input type="checkbox"/> HEAD/FOREHEAD 08 <input type="checkbox"/> LEGS/KNEES/ANKLES 09 <input type="checkbox"/> MULTIPLE AREAS 10 <input type="checkbox"/> NECK 11 <input type="checkbox"/> NO INFORMATION 12 <input type="checkbox"/> SPINE/BACK 13 <input type="checkbox"/> TEETH/MOUTH 14 <input type="checkbox"/> OTHER - <i>Please explain:</i>	
CAUSE OF INJURY OR DAMAGE - <i>Check one only</i>		ACTIVITY AT TIME OF INCIDENT - <i>Check one only</i>		
*01 <input type="checkbox"/> ASSAULT-NO WEAPON (INTENTIONAL) *02 <input type="checkbox"/> ASSAULT-WITH WEAPON (INTENTIONAL) 03 <input type="checkbox"/> CHOKING/SUFFOCATION 04 <input type="checkbox"/> DROWNING 05 <input type="checkbox"/> EXPOSURE TO FLAME/ELECTRICITY/ HOT OR CAUSTIC SUBSTANCE 06 <input type="checkbox"/> FALL AT SAME HEIGHT 07 <input type="checkbox"/> FALL FROM DIFFERENT HEIGHT 08 <input type="checkbox"/> FATIGUE/OVER EXERTION 09 <input type="checkbox"/> FOREIGN BODY *10 <input type="checkbox"/> HORSEPLAY (NO INTENT TO INJURE) 11 <input type="checkbox"/> MAINTENANCE ACTIVITY 12 <input type="checkbox"/> MOTOR VEHICLE ACCIDENT 13 <input type="checkbox"/> POISONING/ALLERGIC REACTION/INSECT BITE 14 <input type="checkbox"/> BUS ACCIDENT 15 <input type="checkbox"/> SPORTS INJURY 16 <input type="checkbox"/> STRUCK AGAINST PERSON 17 <input type="checkbox"/> STRUCK/CRUSHED BY/ AGAINST OBJECT 18 <input type="checkbox"/> OTHER - <i>Please explain:</i> *19 <input type="checkbox"/> SEXUAL ASSAULT (ALLEGATIONS INCLUDED)		01 <input type="checkbox"/> CLASSROOM 02 <input type="checkbox"/> BETWEEN CLASSES 03 <input type="checkbox"/> EXTRA-CURRICULAR (i.e. CLUB) 04 <input type="checkbox"/> OUT-OF-CLASS FIELD TRIP 05 <input type="checkbox"/> PRE-OR POST CLASS 06 <input type="checkbox"/> SPORTS EVENT 07 <input type="checkbox"/> SPORTS RELATED CLASS 08 <input type="checkbox"/> TRAVEL TO OR FROM FACILITY 09 <input type="checkbox"/> UNORGANIZED SPORTS 10 <input type="checkbox"/> WORK PLACEMENT 11 <input type="checkbox"/> MAINTENANCE ACTIVITY 12 <input type="checkbox"/> OTHER - <i>Please explain:</i>		
*List names of others involved:				
<b>2 B</b>	PROPERTY INVOLVED - <i>Describe property involved. Attach additional sheet if more space is required.</i>		ESTIMATE OF LOSS/DAMAGE \$	
	PROPERTY INVOLVED IS: <input type="checkbox"/> OWNED <input type="checkbox"/> LEASED <input type="checkbox"/> PERSONAL		CAUSE OF LOSS/DAMAGE	
	DID THE FIRE DEPARTMENT ATTEND? <input type="checkbox"/> YES <input type="checkbox"/> NO	REPORT NUMBER	01 <input type="checkbox"/> BURGLARY/FORBIC ENTRY 02 <input type="checkbox"/> COLLAPSE 03 <input type="checkbox"/> DISHONESTY/INFIDELITY 04 <input type="checkbox"/> EXPLOSION 05 <input type="checkbox"/> FALLING OBJECT 06 <input type="checkbox"/> FIRE/LIGHTNING 07 <input type="checkbox"/> GLASS BREAKAGE 08 <input type="checkbox"/> IMPACT BY VEHICLE/ AIRCRAFT 09 <input type="checkbox"/> RIOT	
	WERE POLICE NOTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF BRANCH/DETACHMENT	10 <input type="checkbox"/> ROBBERY 11 <input type="checkbox"/> SMOKE 12 <input type="checkbox"/> THEFT 13 <input type="checkbox"/> TRANSPORTATION 14 <input type="checkbox"/> VANDALISM/ MALICIOUS ACTS 15 <input type="checkbox"/> WATER/ESCAPE RUPTURE/FREEZING 16 <input type="checkbox"/> WINDSTORM/HAIL 17 <input type="checkbox"/> OTHER - <i>Please Explain:</i>	
	WERE THERE VISIBLE SIGNS OF FORCED ENTRY? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If YES, please explain:</i>	CASE NUMBER		
<b>3</b>	FULL NAME OF PERSON COMPLETING REPORT - <i>Please print</i>		TITLE	
	SIGNATURE		DATE SIGNED YYYY MM DD	
	FULL NAME OF ADMINISTRATOR - <i>Please print</i>		SIGNATURE	
DATE SIGNED YYYY MM DD		OTHER INFORMATION/COMMENTS/UPDATE?		