# **Incident Form**

To be completed within 12 hours of the incident/accident occurring

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| --- | --- | --- | --- | --- |
| Date of Incident |  | | Time for incident |  |
| Injured person’s name | |  | | |
| Location of Incident | |  | | |
| Name of person reporting the incident | |  | | |
| Date of Report |  | |  |  |

## Description of the Incident

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## Description of Injuries (if applicable)

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## Actions taken (e.g. first aid, ambulance called)

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## Office use:

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| --- | --- |
| Report received by |  |
| Date |  |
| Action | * Investigation * Reportable Incident * Continuous Improvement review |
| Comments |  |