

Critical Incident Report Form

Type of Incident (please tick)

Injury to staff <input type="checkbox"/>	Injury to student <input type="checkbox"/>	Theft / Loss <input type="checkbox"/>	Property damage <input type="checkbox"/>
Vehicle accident <input type="checkbox"/>	Environmental damage <input type="checkbox"/>	Fire <input type="checkbox"/>	Assault <input type="checkbox"/>
			Other <input type="checkbox"/>

Details of Critical Incident

Date: _____ Time: _____ am pm

Location: _____

Person(s) involved (including witnesses)

Name	Address	Phone No

What activity or program was underway?

Description of Incident

Description of Injury

Description of damage

Reported to Police? Yes No

Did any other service attend? (If yes, attach a copy of the report)

Reported By: _____ Signature: _____

Chief Executive Officer recommended action

Signature: _____ Date _____