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| **INCIDENT REPORT FORM** |
| **Incident Report Form**  |
| 1. **GENERAL INFORMATION**
 |
| Date of Incident: | Time: a.m p.m. |
| Name:  Job Title:  |
| Location of Incident:\_\_\_\_\_\_\_ Office\_\_\_\_\_\_\_ Reception Area\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_ Service Department\_\_\_\_\_\_\_ Parts Department\_\_\_\_\_\_\_\_ Other (please specify)  |
| Type of assault:  \_\_\_\_\_\_ Verbal \_\_\_\_\_\_Physical |
| **2. DETAILED DESCRIPTION OF INCIDENT** |
| Describe Incident: (use additional sheets if required) |
| **Incident Report Form – pg 2** |
| Name of Supervisor notified: |
| Workplace Safety and Health Division called? \_\_\_\_\_Yes \_\_\_\_\_\_\_No |
| Police called? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No |
| Safety and Health Committee notified? \_\_\_\_\_\_Yes \_\_\_\_\_\_\_No |
| Were you advised to seek medical treatment? \_\_\_\_\_\_\_\_Yes \_\_\_\_\_No |
| Did you consult a doctor? \_\_\_\_\_\_Yes \_\_\_\_\_\_No |
| Medical attention, first aid obtained? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No |
| Did an investigation occur? \_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No |
| WCB forms completed? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No |
| 1. **INFORMATION ABOUT THE ASSAILANT**
 |
| \_\_\_\_\_Customer \_\_\_\_\_\_\_Co-worker \_\_\_\_\_Other (specify)  |
| Name and address of suspect if known: |
| 1. **IMMEDIATE ACTION TAKEN BY THE EMPLOYER**
 |
| 1. **DIRECT & INDIRECT CAUSES (Attach any pictures, graphs, etc)**
 |
| 1. **RECOMMENDATIONS**
 |
| **COMPLETED ON**  |