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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** | |