

CFOC INCIDENT REPORT FORM

Person(s) involved:		
Date: MM/DD/YYYY	Time:	Location:
Type of incident (please circle below):		
Injury	Illness	Environmental
Notifiable event	Other:	
Reported by:		
Role in the event:		
Person(s) injured (if applicable):		
Name:		
Witness(s):		
Name:		Phone:
Name:		Phone:
Name:		Phone:
Describe the incident: (space overleaf for diagram if needed)		
Describe any illness or injury: What part of the body is affected and how?		
Were emergency services required? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, incident report #:		
What was the outcome:		
What was the immediate treatment given? Describe in detail:		
Was the Staff/Department Lead notified? If yes, please name & Date. Yes <input type="checkbox"/> No <input type="checkbox"/>		
Dept Lead/Staff Name:		Date
If no, please explain:		
If It was a minor (under 18 years), were parent(s) or guardian(s) notified? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Guardian Response?		
Describe any property damage: What damage was caused and how?		
Analysis: What do you think caused or contributed to the incident?		

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Prevention: What action has been taken to prevent a reoccurrence?	
Have all preventative actions been reviewed by the Staff/Management, and implemented?	
Yes <input type="checkbox"/> No <input type="checkbox"/> If no, Please provide details:	
Staff Signature:	Date completed:
Parent/Guardian Name:	Date completed:
Parent/Guardian Signature:	Date completed: