



INCIDENT REPORT FORM

All forms are to remain on file in the Office of the Director of Facilities Management.

Submit this form to the Director of Facilities Management

No references to the identity of the individual shall be included on this form.

Date of Incident: _____ Reported by _____

Dept.: _____ Dept. Head: _____

Nature of Incident:

Area of Incident: _____ Room No. _____

Time of Incident: _____ Condition of Area: _____

Medical Attention Required: Yes ___ No ___ Work days
Lost? Yes ___ No ___
Nature of Medical Attention:

Was Person Taken to Hospital? Yes ___ No ___
How _____

Which Hospital? _____ Accompanied? _____

Hazardous Conditions Present?

Recommendations for Prevention:

Date: _____ Time _____

Signed: _____

Actions Taken by Facilities Management:

Date: _____ Time: _____ By

Whom: _____

Date Presented to Occupational Health and Safety:

Further Action Required? Yes _____ No

Nature of Further Action Required:

Completion Date: _____ By

Whom _____

Cc Occupational Health & Safety Committee
 Director, Facilities Management
 Dean
 Division Chair