



CRITICAL INCIDENT REPORT FORM

Part A		
Details of Person Completing the Form	Name:	
	Phone no:	
	Email address:	
Date and Time of Incident		
Location of the Incident		
Brief Description of Incident	Type of Incident:	
	Description of Incident:	
Name and Contact Details for Witnesses to the Incident		
Was anyone injured?	<input type="checkbox"/> No (Complete Part C)	<input type="checkbox"/> Yes (Complete part B)

Part B		
Details of Injured Person	Name:	
	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other/Please specify: _____
	Date of Birth:	
	Contact Details:	
	Emergency Contact Details:	
Description of Injury		
Treatment Required	<input type="checkbox"/> No <input type="checkbox"/> First Aid <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital admission <input type="checkbox"/> Other, please specify: _____	



Part C – Additional Details		
Description of Damage:		
Were there any other services involved/attended? <i>(e.g., police, ambulance, fire)</i> <i>(If yes, attach a copy of the report)</i>		
Person/s involved		
Name	Contact Number	Address
Recommended Actions Taken by International Institute of Training (IIT)		
Checklist <ul style="list-style-type: none"> <input type="checkbox"/> Incident entered into Critical Incident Register <input type="checkbox"/> PRISMS notification required? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, date submitted: _____) <input type="checkbox"/> Follow-up counselling or support provided <input type="checkbox"/> Referred for continuous improvement review <input type="checkbox"/> Document filed in accordance with Records Management Policy 		
Signature:	Date:	