

Incident Information			
General			
Incident Date:		Time of Incident: AM PM	
Date Reported:		Time Reported: AM PM	
Reported to whom:			
Location of Incident			
Person(s) Involved			
Name:		Position:	
Name:		Position:	
Name:		Position:	
Witness(s) and/or those providing assistance <i>(complete contact information if not TLC worker)</i>			
Name:		Contact Information <i>(i.e. phone number)</i> :	
Name:		Contact Information <i>(i.e. phone number)</i> :	
Name:		Contact Information <i>(i.e. phone number)</i> :	
Name:		Contact Information <i>(i.e. phone number)</i> :	
For Injury Incidents			
First aid given: No Yes by whom?: First aid form completed No Yes			
Was medical attention required: No Yes if yes, was WCB forms completed No Yes			
Describe Injury:			
Description the incident: Explain in detail how it happened i.e. in a lifting incident; include size & weight of objects involved and where it was being lifted from and to. What equipment, tools, materials, etc. were involved? What was the task being performed? What happened?			

SUBMIT

Signature