COMOX VALLEY CHILD DEVELOPMENT ASSOCIATION
CRITICAL INCIDENT REPORT #_____

Date and Time:			**Location:** *(please specify)*
Type of Incident: ☐ Biohazardous accidents ☐ Bodily Injury ☐ Earthquake ☐ Wandering or missing ☐ Explosion ☐ Fire ☐ Flood ☐ Infection control ☐ Medication errors ☐ Neglect ☐ Physical abuse ☐ Violence or aggression	☐ Sexual abuse ☐ Suicide or attempted suicide ☐ Unexpected death ☐ Unexpected illness ☐ Use or possession of illicit substances ☐ Use or possession of weapons ☐ Vehicular Accident ☐ Other	**911 called:** ☐ Yes ☐ No **Medical Attention Obtained:** ☐ Yes-see first aid report ☐ Yes-see Worker's Report of Injury (form 6A) ☐ No-why not? **Police Report:** ☐ Yes ☐ No **Insurance Company Notified:** ☐ Yes ☐ No	**Names of People Involved:** (use back of form if necessary) *(fill out WCB form for each injured staff and a separate critical incident form for any other injured person)* 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ 13. _____ 14. _____

Describe in Detail:
(use additional paper if necessary)

Action taken:

Outcome:

Please provide any other information you think is relevant:

Name of reporter:	**Signature:**
Position in organization:	
Date Reviewed by OH&S:	

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Length of experience in this position:

Statement of causes:

List any unsafe conditions, acts, or procedures that in any manner contributed to the incident:

Recommendations:

Identify any corrective actions that have been taken and any recommended actions to prevent similar incidents:		
Recommended corrective action	Action by whom	Action by date
1)		
2)		
3)		
4)		

Persons conducting response:

Name	Initials	Type of representative			Date
		Employer ☐	Worker ☐	Other ☐	
		Employer ☐	Worker ☐	Other ☐	
		Employer ☐	Worker ☐	Other ☐	

Follow-Up:

Short-term: Long-term: