**ACCIDENT, INCIDENT & OCCUPATIONAL DISEASE REPORT FORM 2019-2020**

***BFL CANADA***

2001, McGill Collège, bureau 2200

Montréal, Québec H3A 1G1

Tel : 514-843-3632

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**INJURED PARTY/COMPLAINANT** to **COMPLETE** sections A & B, SIGN**, DATE & SUBMIT** to your immediate supervisor/department within 24 HOURS of the event.

 **PLEASE PRINT CLEARLY WITH A BLUE OR BLACK PEN**

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| **Section A: General Information (Injured Party / Complainant)*****Fill left side if employee is victim of the accident/incident and right side if it is a student or visitor*** |
| **EMPLOYEE**  | **STUDENT  OR VISITOR**  |
| **Employee’s full name:** **Date of birth:**Support  Teacher  Professional  Admin. **Job title :****Daytime phone number :****Evening phone number :** | **Full name (student or visitor) :** **Grade:****Date of birth : Age:****Mother / Father / Guardian’s Name :****Parent daytime phone number :****Parent evening phone number :****Student complete address :** |
| **Section B: Description of the Event** |
| **WHEN** Date of Event: Time of Event:Date Reported: Time Reported: |
| **WHERE** School name :Location of Event (Room #, lab, playground, stairs, etc.): Witness: Phone:  |
| **WHAT** happened? (Description of the event and how it occurred) |
| Were you injured? YES NO If YES, provide a description of injury, including parts of body |
| Was First Aid administered? YES NO If YES, by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Description of First Aid:Other measures: YES NOParent contacted (if student) By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Completed day Transfer to hospital Ambulance  Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Signature Date** |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Injured Party’s Signature Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Principal’s Signature Date**If this form was completed by someone other than the injured party, please fill out the following:** |
| Form completed by: Phone Number: |
| Signature : Date:  |

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