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

***BFL CANADA***

2001, McGill Collège, bureau 2200

Montréal, Québec H3A 1G1

Tel : 514-843-3632

Fax : 514-843-3842

**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 NO  Parent 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: | |

340 rue Saint-Jean-Bosco

Magog, QC J1X 1K9 Tel: 819-868-3100 / Fax: 819-868-2286