**ACCIDENT, INCIDENT & OCCUPATIONAL DISEASE REPORT FORM 2017-2018**

***BFL CANADA***

2001, McGill Collège, bureau 2200

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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. A copy must be sent to Buildings & Grounds

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| **Section A: General Information (Injured Party / Complainant)** | |
| **Last Name** | **First Name** |
| **Status**  Employee Student Visitor Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Address**  Grade: \_\_\_\_\_\_\_\_\_\_\_ | |
| **Daytime Phone Number** | **Evening Phone Number** |
| **Mother / Father / Guardian’s Name** | |
| **Section B: Description of the Event** | |
| **When** Date of Event: Time of Event:  Date Reported: Time Reported: | |
| **Where** Location of Event (Lab, playground, stairs, etc.) School:    Witness: Phone: | |
| **What** happened? (Description of the event and how it occurred) | |
| Were you injured? (Description of injury, including parts of body) | |
| Was First Aid administered? YES NO If YES, by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Description of First Aid: | |
| If it was a student, was: YES NO  Parent contacted By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Taken home By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Transfer to hospital By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **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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