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

***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. A copy must be sent to Buildings & Grounds

|  |
| --- |
| **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 NOParent contacted By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Taken home By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Transfer to hospital By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Signature Date** |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Injured Party’s Signature Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Principal’s Signature DateIf 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