



# INCIDENT REPORT

## INCIDENT DETAILS

Date of incident:  
Type of incident:  
Specific Location:  
Day of the week: Time:

## AFFECTED PERSON

Full name:  
Address:  
  
Phone number  
(home):  
(mobile):  
(work):  
  
Email:  
Date of Birth:

## REPORT

Reported by: Position:  
Reported to: Position:  
Date reported: Time:  
Reported to parent/guardian: By whom: Date:

## TREATMENT INFORMATION

First Aid: Yes  No  Doctor: Yes  No  Ambulance: Yes  No

## DETAILS OF ALLEGED INJURY

File Name: Incident Report v1.0		Department:	
ECCD Number:	Last Modified: 16/07/2019	Modified By: Bec Neal	Approved By:
File Location: Document1			
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**WITNESS INFORMATION**

**Witness 1**

Full name:  
Address:  
Phone number  
    (home):  
    (mobile):  
    (work):  
Email:  
Date of Birth:

**Witness 2**

Full name:  
Address:  
Phone number  
    (home):  
    (mobile):  
    (work):  
Email:  
Date of Birth:

**Witness 3**

Full name:  
Address:  
Phone number  
    (home):  
    (mobile):  
    (work):  
Email:  
Date of Birth:

**ACTION TAKEN**

**PERSON COMPLETING FORM:**

Name: Position:  
Mobile: Email:  
Signed: Date:

**NOTE: Do not give a copy of this report to the affected person.  
Print and sign this completed form and keep with the Safe Ministry records indefinitely.**

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