

INCIDENT REPORT FORM

ALL INCIDENTS ARE TO BE REPORTED IMMEDIATELY AND SUBMITTED BEFORE THE END OF THE SHIFT.

This form should be completed by the Captain, Department Manager/Supervisor, or Safety Services (Niagara). All hardcopy Incident Report Forms must be submitted to the appropriate team for record retention.

Crew incidents/injuries, send completed form to Human Resources at Canadahr@cityexperiences.com.

All other incidents and near misses, send completed form to Kelly Di Lapo at kelly.dilapo@cityexperiences.com.

FILL THIS FORM OUT COMPLETELY and with as much detail as possible after the incident has been safely resolved.

A. INCIDENT INFORMATION		
Type of Incident (Damage to Property, Environmental Release, Illness, Injury, Near Miss):		
Location of Incident:	Department:	
Date of Incident:	Time of Incident:	Incident Reported to (Name & Position):
Date Reported:	Time Reported:	
Describe Exactly Where the Incident Occurred:		
Was this a pre-existing injury? (i.e. did the injury occur at home/off-site?) <input type="checkbox"/> Yes <input type="checkbox"/> No		
B. INCIDENT DETAILS		
Brief Description of Incident:		
Detailed Description of Incident:		
Action(s) Taken (choose all that apply):		
<input type="checkbox"/> Notified Transport Canada	<input type="checkbox"/> Notified Canadian Coast Guard	<input type="checkbox"/> Notified Police
<input type="checkbox"/> Notified Supervisor	<input type="checkbox"/> Notified Landlord (NPC, Harbourfront)	<input type="checkbox"/> Contacted Third Party Responder
<input type="checkbox"/> Notified Government Agency	<input type="checkbox"/> Used Automatic External Defibrillator (AED)	<input type="checkbox"/> Provided First Aid
<input type="checkbox"/> Individual Declined First Aid	<input type="checkbox"/> Contacted Emergency Medical Services	<input type="checkbox"/> Taken to Hospital
<input type="checkbox"/> Other (Provide Description):		
<input type="checkbox"/> No Action Taken (Provide Reason):		

PLEASE COMPLETE THE APPLICABLE SECTION(S) BELOW.

C. PERSONAL INFORMATION			
Crew or Guest:		Name(s):	
Address:		Date of Birth:	
Phone Number:		Gender:	
D. INJURY OR ILLNESS			
Category of injury or illness (choose all that apply):			
<input type="checkbox"/> Struck/Caught	<input type="checkbox"/> Fire/Explosion	<input type="checkbox"/> Assault	
<input type="checkbox"/> Overexertion	<input type="checkbox"/> Fall	<input type="checkbox"/> Slip/Trip	
<input type="checkbox"/> Repetition	<input type="checkbox"/> Harmful substances/environmental	<input type="checkbox"/> Motor Vehicle Incident	
<input type="checkbox"/> Other (Please specify):			
Type of Injury or Illness (choose all that apply):			
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Amputation	<input type="checkbox"/> Animal/Insect Exposure
<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Chemical Burn	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Concussion
<input type="checkbox"/> Contusion/Bruise	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Electric Shock
<input type="checkbox"/> Epilepsy/Seizure	<input type="checkbox"/> Fracture	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Heat Stress
<input type="checkbox"/> Hypothermia/Frostbite	<input type="checkbox"/> Incision/Laceration	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Loss of Consciousness
<input type="checkbox"/> Puncture	<input type="checkbox"/> Respiratory Irritation	<input type="checkbox"/> Skin Irritation	<input type="checkbox"/> Sprain/Strain
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thermal Burn	<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Other
If "Other", Provide Description:			
Body Part(s) Affected: (choose all that apply):			
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ear	Left	Right
<input type="checkbox"/> Back (Lower)	<input type="checkbox"/> Chest	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hip
<input type="checkbox"/> Back (Upper)	<input type="checkbox"/> Neck	<input type="checkbox"/> Arm	<input type="checkbox"/> Thigh
<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Elbow	<input type="checkbox"/> Knee
<input type="checkbox"/> Face	<input type="checkbox"/> Lung	<input type="checkbox"/> Forearm	<input type="checkbox"/> Lower Leg
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Skin	<input type="checkbox"/> Wrist	<input type="checkbox"/> Ankle
<input type="checkbox"/> Groin	<input type="checkbox"/> Internal Organs	<input type="checkbox"/> Hand	<input type="checkbox"/> Foot
<input type="checkbox"/> Nervous System	<input type="checkbox"/> Reproductive System	<input type="checkbox"/> Finger(s)	<input type="checkbox"/> Toe(s)
<input type="checkbox"/> Other (Provide Description):			
E. ENVIRONMENTAL RELEASE			
If a third-party emergency Responder is called, provide the details:			
If a Government Agency is notified, provide the name of the contact:			

F. WITNESS DETAILS	
Crew or Guest:	Name and Phone Number:
Address:	
Additional Information (if applicable):	
G. HEALTH CARE	
Did the crew member receive health care for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes, when?	When did you learn the crew member received health care? (dd/mm/yy)
If known, where was the worker treated for this injury? <input type="checkbox"/> Health professional office <input type="checkbox"/> Clinic <input type="checkbox"/> Ambulance <input type="checkbox"/> Emergency Department <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Other:	
H. SIGNATURE	
<i>I have completed this form to the best of my ability regarding the incident at hand. I have made honest and accurate accounts to the best of my knowledge. I have not provided any false statements of information.</i>	
Report Filled Out By:	Position:
Signature:	Date:
If this involved a crew injury, please send completed report to Human Resources immediately at Canadahr@cityexperiences.com If this involved property damage or other incidents, please send completed report to Kelly Di Lapo at Kelly.dilapo@cityexperiences.com	

