



PLEASE COMPLETE THE APPLICABLE SECTION(S) BELOW.

C. PERSONAL INFORMATION			
<b>Crew or Guest:</b>		<b>Name(s):</b>	
<b>Address:</b>		<b>Date of Birth:</b>	
<b>Phone Number:</b>		<b>Gender:</b>	
D. INJURY OR ILLNESS			
<b>Category of injury or illness (choose all that apply):</b>			
<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):			
<b>Type of Injury or Illness (choose all that apply):</b>			
<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:			
<b>Body Part(s) Affected: (choose all that apply):</b>			
<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			
<b>If a third-party emergency Responder is called, provide the details:</b>			
<b>If a Government Agency is notified, provide the name of the contact:</b>			

F. WITNESS DETAILS	
<b>Crew or Guest:</b>	<b>Name and Phone Number:</b>
<b>Address:</b>	
<b>Additional Information (if applicable):</b>	
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>	
<b>Report Filled Out By:</b>	<b>Position:</b>
<b>Signature:</b>	<b>Date:</b>
<b>If this involved a crew injury, please send completed report to Human Resources immediately at <a href="mailto:Canadahr@cityexperiences.com">Canadahr@cityexperiences.com</a></b> <b>If this involved property damage or other incidents, please send completed report to Kelly Di Lapo at <a href="mailto:Kelly.dilapo@cityexperiences.com">Kelly.dilapo@cityexperiences.com</a></b>	

