



INCIDENT REPORT PLEASE COMPLETE NON-SHADED AREAS IN FULL IR #

FACILITY INFORMATION	FACILITY NAME	FACILITY LICENCE NUMBER	
	ADDRESS	PHONE NUMBER	
INVOLVED PERSONS	NAME OF PERSON IN CARE (1)	DATE OF BIRTH DD/MM/YYYY	SEX M F NON-BINARY
	NAME OF PERSON IN CARE (2)	DATE OF BIRTH DD/MM/YYYY	SEX M F NON-BINARY
	STAFF VISITOR OTHER (SPECIFY)	NUMBER OF PERSONS IN CARE AFFECTED	

TYPE OF INCIDENT BEING REPORTED: AGGRESSIVE/UNUSUAL BEHAVIOUR AGGRESSION BETWEEN PERSONS IN CARE [Res. Care Only] ATTEMPTED SUICIDE CHOKING DEATH EXPECTED UNEXPECTED DISEASE OUTBREAK OR OCCURENCE EMERGENCY RESTRAINT EMOTIONAL ABUSE FALL FINANCIAL ABUSE FOOD POISONING MEDICATION ERROR MISSING/WANDERING MOTOR VEHICLE INJURY NEGLIGENCE POISONING PHYSICAL ABUSE SERVICE DELIVERY PROBLEMS SEXUAL ABUSE UNEXPECTED ILLNESS OTHER INJURY _____	INDICATE TYPE OF INJURY BEING REPORTED & EQUIPMENT INVOLVED: TYPE OF INJURY (all service types to complete): BRUISE/CONTUSION DISLOCATION SPRAIN/STRAIN BURN FRACTURE SURFACE CUT/SCRATCH CONCUSSION LACERATION/ABRASION OTHER _____ NO INJURY	LOCATION OF INCIDENT (CHOOSE ONE OF THE FOLLOWING): RESIDENTIAL CARE CHILD CARE – INDOOR EXCLUDING PLAYGROUND CHILD CARE – INDOOR PLAYGROUND CHILD CARE – OUTDOOR EXCLUDING PLAYGROUND CHILD CARE – OUTDOOR PLAYGROUND																																									
	EQUIPMENT (child care only): SWING SLIDING POLE SLIDE HORIZONTAL LADDER/MONKEY BARS SEESAW ROPE-LADDER COMPOSITE CLIMBER OTHER _____	<table border="0"> <tr> <td>NOTIFIED</td> <td>DATE</td> <td>TIME</td> </tr> <tr> <td>HEALTH CARE PROVIDER</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>POLICE</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>LICENSING/MHO</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>CORONER</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>OTHER (SPECIFY)</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>AMBULANCE</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>MCF</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>MANAGER</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>FIRE DEPARTMENT</td> <td>_____</td> <td>_____</td> </tr> <tr> <td colspan="3">PARENT/REPRESENTATIVE/CONTACT PERSON CONTACTED</td> </tr> <tr> <td>YES NO DATE/TIME</td> <td>_____</td> <td>_____</td> </tr> <tr> <td colspan="3">NAME OF PERSON NOTIFIED _____</td> </tr> <tr> <td colspan="3">PHONE NUMBER _____</td> </tr> </table>	NOTIFIED	DATE	TIME	HEALTH CARE PROVIDER	_____	_____	POLICE	_____	_____	LICENSING/MHO	_____	_____	CORONER	_____	_____	OTHER (SPECIFY)	_____	_____	AMBULANCE	_____	_____	MCF	_____	_____	MANAGER	_____	_____	FIRE DEPARTMENT	_____	_____	PARENT/REPRESENTATIVE/CONTACT PERSON CONTACTED			YES NO DATE/TIME	_____	_____	NAME OF PERSON NOTIFIED _____			PHONE NUMBER _____	
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DETAILS OF INCIDENT AND FOLLOW UP (ATTACH ADDITIONAL PAGES IF NECESSARY)

DATE OF INCIDENT	TIME OF INCIDENT	INDICATE SERVICE TYPE (If applicable):

SIGNATURES	NAME	POSITION	SIGNATURE	DATE	TIME
Witness/Attending Staff:					
Form Completed by:					
Licensee/Manager					

Reported to Licensing	THIS SECTION TO BE COMPLETED BY THE LICENSING OFFICER UPON RECEIPT OF REPORT (ATTACH ADDITIONAL PAGES IF NECESSARY)	
Day/Month/Year	NOTIFICATION COMMENTS	

Type of Incident Confirmed by Licensing	AGGRESSIVE/UNUSUAL BEHAVIOUR ATTEMPTED SUICIDE DEATH EXPECTED DISEASE OUTBREAK OR OCCURENCE EMERGENCY RESTRAINT EMOTIONAL ABUSE MEDICATION ERROR MOTOR VEHICLE INJURY OTHER INJURY POISONING SERVICE DELIVERY PROBLEMS INCIDENT CONFIRMED	AGGR. BTWN PERSONS IN CARE (res. care only) CHOKING DEATH UNEXPECTED FALL FINANCIAL ABUSE FOOD POISONING MISSING/WANDERING NEGLIGENCE PHYSICAL ABUSE SEXUAL ABUSE UNEXPECTED ILLNESS	Residential Care Licensing Officers complete this box if confirmed MISSING/WANDERING or AGGR. BTWN PIC: OUTCOME: NOT FOUND [Missing/wandering only] UNHARMED [Missing/wandering only] FIRST AID PROVIDED [Missing/wandering only] EMERG. Care by MD, NP or Transfer to Hospital DEATH

Death Reported to Coroner	Reported to Coroner by Facility	Reported to Coroner after Licensing Review	Not Reported to Coroner
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Confirm Type of Injury & Equipment	TYPE OF INJURY:			EQUIPMENT(Child Care Playground Incidents):		
	BURN CONCUSSION LACERATION/ABRASION OTHER _____	FRACTURE DISLOCATION	BRUISE/CONTUSION SPRAIN/STRAIN SURFACE CUT/SCRATCH NO INJURY	COMPOSITE CLIMBER HORIZ. LADDER/ MONKEY BARS ROPE-LADDER SLIDING POLE	SEESAW SLIDE OTHER _____	
Indicate Service Type Confirmed: _____						

Licensing Follow-Up	No Follow-up Required by Licensing	Follow-up Required by Licensing	Licensing Follow-up Complete: DD/MM/YYYY	Not a Reportable Incident
	COMMENTS:			
	Licensing Officer's Name [Print]	Signature	Date	Page ___ of ___