



Incident Report

Student Information	Last Name _____		Telephone () _____ - _____	
	FirstName _____	Date of Birth _____ / / (DD/MM/YY)	Passbook # _____	
Address _____ City/Town _____ Province _____ Postal Code _____				
Description of Incident	Date of Incident (DD/MM/YY) _____ / _____ / _____		Date Reported (DD/MM/YY) _____ / _____ / _____	
	Time _____ AM/PM		Time _____ AM/PM	
State the exact sequence of events leading up to the incident. Include an explanation of what the member was doing.		At what location did the accident happen?		Identify the safety equipment being used:
_____		_____		_____

_____		What caused the injury / illness?		_____

_____		_____		Type of Incident
				<input type="checkbox"/> Struck / Caught <input type="checkbox"/> Overexertion <input type="checkbox"/> Fall <input type="checkbox"/> Assault <input type="checkbox"/> Slip / Trip <input type="checkbox"/> Other
Injury	Describe the illness or injury, part of body involved and specify left or right side.			
	Was First Aid administered? If so, by whom. Include specific actions.			
Follow up	Did the member seek medical attention? If so where?			
	Has the member received approval from a physician to resume Training. Attach written approval to this form			
Yes <input type="checkbox"/> No <input type="checkbox"/> Physician Name: _____ Contact () _____ - _____				
STUDENT SIGNATURE _____		Instructor Signature _____		K.K.L Signature _____
Date _____		Date _____		Date _____