



Critical Incident Report Form

Type of Incident (please tick)

- | | | |
|--|---|----------------------------------|
| <input type="checkbox"/> Injury to staff | <input type="checkbox"/> Vehicle accident | <input type="checkbox"/> Fire |
| <input type="checkbox"/> Property damage | <input type="checkbox"/> Theft / Loss | <input type="checkbox"/> Assault |
| <input type="checkbox"/> Injury to student | <input type="checkbox"/> Environmental damage | <input type="checkbox"/> Other |

If Other (Please specify):

Time and Location of Critical Incident

Date: _____ Time: _____ AM / PM

Location: _____

Person(s) involved (including witnesses)

| Name | Address | Phone Number |
|------|---------|--------------|
| | | |
| | | |
| | | |
| | | |
| | | |

What activity or program was underway?



Description of Incident

Description of Injury

Description of damage

Were any other services involved / attended? (If yes, Please attach a copy of the report)

Received By:

Signature:

Chief Executive Officer recommended action (Added to relevant registers of NAIT)

Signature:

Date: