

INCIDENT REPORT

★ SEND THIS FORM TO : incidentsmineurs@abernier.ca

INCIDENT DATE : ____/____/____ POLICY NO : 166-6500 CUSTOMER NUMBER : 16_-____ CUSTOMER CODE: _____

BC / CPE / DAYCARE / REGROUPEMENT : _____

FULL ADDRESS : _____

PHONE NUMBER : _____

DIRECTOR / COORDINATOR/PROVIDER: _____

INJURED : _____ DATE OF BIRTH : ____/____/____

PARENT : _____

FULL ADDRESS : _____

PHONE NUMBER : _____

PERSON CONTACTED : _____ DATE : ____/____/____ TIME : _____

SCENE OF THE INCIDENT : _____

NAME OF PROVIDER IN CHARGE AT THE TIME OF THE INCIDENT: _____

DESCRIBE AND INDICATE THE INJURY (IES):

IMMÉDIATE MEASURES (FIRST AID) :

TRANSPORTATION TO HEALTH SERVICES : OUI NON

NAME OF HOSPITAL : _____

ADDRESS : _____

EXAMINED AT EMERGENCY : OUI NON HOSPITALISED : OUI NON ROOM NO: _____

WITNESS 1. NAME _____ TEL : () _____

WITNESS 2. NAME _____ TEL : () _____

I (PARENT/GUARDIAN) ACKNOWLEDGE HAVING BEEN INFORMED OF THE INCIDENT AS DESCRIBE IN THIS DOCUMENT.

SIGNATURE _____ DATE : ____/____/____
PARENT/GUARDIAN

SIGNATURE _____ DATE : ____/____/____
DIRECTOR / COORDINATOR/PROVIDER

