

## Critical Incident Record Form

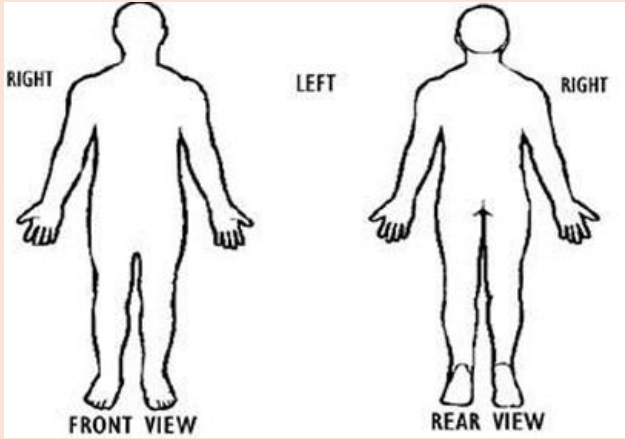
### Purpose

This document serves as a record of the critical incident, detailing the date, time, location, personnel involved in handling the situation, and a description of the incident that occurred. This form helps in analysing the critical incidents, identifying any patterns, and implementing actions to prevent similar incidents in the future. This form is to be filled by the Compliance Officer<sup>1</sup> or any college staff as designated by the compliance officer.

| Details of person involved in the incident   |  |
|--|--|
| <input type="checkbox"/> Student   | <input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Vendor |
| Full name  |  |
| Student ID (if applicable)   |  |
| Home address   |  |
| Occupation   |  |
| Date of birth  |  |
| Contact number   |  |
| Email  |  |
| <b>If the person involved in the incident was a visitor or vendor, please specify:</b> |  |
| Employer (if applicable)   |  |
| Was there another person/s involved?   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Name of other person/s involved  |  |
| Contact number   |  |
| Email  |  |
| <b>If the person involved in the incident was an Employee, please specify:</b>         |  |
| Employee Name and Designation  |  |
| Line Manager   |  |
| Name of other person/s involved  |  |
| Location<br>(Campus/Workshop/Restaurant/other)   |  |
| Was the employee emergency contact person notified?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes,<br>Emergency Contact Name:     |

<sup>1</sup> The term compliance officer includes chief compliance officer and compliance officer(s).  
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|  |  |
|--|--|
|  | Contact Number:  |
| Did the employee leave work on the day of the incident?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, what time? <input type="checkbox"/> am <input type="checkbox"/> pm   |
| Did the employee return to work on the day of the incident?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, what time? <input type="checkbox"/> am <input type="checkbox"/> pm   |
| <b>If the person involved in the incident was a student, please specify:</b> |  |
| Trainer or name of other staff member (if present)                           |  |
| Location (Campus/Workshop/Restaurant/other)                                  |  |
| Was the student emergency contact person notified?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes,<br>Emergency Contact Name:<br>Emergency Contact Number:  |
| Is the student under 18?   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, was the student's guardian contacted?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Guardian Name:<br>Guardian Contact: |
| Did the student leave the campus on the day of the incident?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, what time? <input type="checkbox"/> am <input type="checkbox"/> pm   |
| Did the student return to the campus on the day of the incident?             | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, what time? <input type="checkbox"/> am <input type="checkbox"/> pm   |
| <b>Details of the incident</b>   |  |
| Date   |  |
| Time   | <input type="checkbox"/> am <input type="checkbox"/> pm  |
| Specific location of incident (if applicable)                                |  |
| Emergency Services or Police called?   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, did Emergency Services attend?   |

|   |   |
|---|---|
|   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Incident type   | <input type="checkbox"/> Injury – First Aid<br><input type="checkbox"/> Injury – Medical/Emergency Treatment<br><input type="checkbox"/> Property Damage<br><input type="checkbox"/> Equipment Failure<br><input type="checkbox"/> Theft<br><input type="checkbox"/> Other, please specify: |
| <b>If the incident involved an injury, please provide details below:</b>  |   |
| Nature of injury <i>e.g., fracture, burn, sprain, foreign body in eye</i> |   |
| Body location of injury (indicate location of injury on the diagram)      |   |
| Was medical treatment provided?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Treatment refused   |
| Where was treatment provided?   | <input type="checkbox"/> Onsite <input type="checkbox"/> Hospital<br><input type="checkbox"/> Other, specify:   |

**Description of incident (be as specific as possible)**

|  |
|--|
|  |
|--|

**Witness to the incident (witnesses may need to provide an account of what happened)**

|   |  |
|---|--|
| Were there witnesses to the incident?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please provide witness names and contact numbers: (if required, please attach an additional sheet with witness information) |  |
| Witness 1 Full Name   |  |
| Witness 1 Contact Number  |  |
| Witness 2 Full Name   |  |
| Witness 2 Contact Number  |  |

**Further action taken (if applicable)**

|                      |  |
|----------------------|--|
| Police report filed? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reporting Officer    |  |
| Contact information  |  |
| Follow up action     |  |

**Completed by (COLLEGE STAFF USE ONLY)**

|           |  |
|-----------|--|
| Full name |  |
| Position  |  |
| Signature |  |
| Date      |  |