



Critical Incident Reporting Form

Person completing this form	
Full Name:	
Relationship to the RTO:	<input type="checkbox"/> Staff member <input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Other (<i>please specify</i>) _____
Date of completing this form:	
Incident Details	
Description of how, where and when the incident occurred?	
Please identify any hazards that contribute to this incident occurring?	
List the person(s) involved in the incident?	
Cause of incident (if known at the time of reporting)?	
Body part(s) injured if any?	
Did anyone require any medical treatment?	



Referral to external body/bodies?	
Description of remedial action/s taken?	
Description of outcome/s following the execution of remedial action/s? (if known at the time of reporting)	
Signature(s)	

