**VOLLEYBALL BC INCIDENT/INJURY REPORT FORM**

# STAFF INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Reportee Name: |       | Date of Incident: |       |
| Reportee Position: |       | Location of Incident: |       |

# INCIDENT/INJURY/SUSPECT INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |       | Birth Date:(YYYY/MM/DD) |       |
| Phone Number: |       | Time of Incident: |       |
| Address: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  INJURY | [ ]  MEDICAL EMERGENCY | [ ]  UNRULY PERSON | [ ]  PHYSICAL ASSAULT |
| [ ]  FIRST AID ADMINISTERED | [ ]  POWER OUTAGE | [ ]  MISSING PERSON | [ ]  THEFT |
| [ ]  NATURAL DISASTER | [ ]  OTHER: |

# INCIDENT SUMMARY

|  |
| --- |
| Please provide a comprehensive summary of what occurred:*If there was an injury, medical emergency, or first aid was administered, please describe the injury and/or what first aid was administered. If there was a suspect but you do not have their information, please provide a description (height, weight, build, ethnicity, hair colour, etc.) if possible.*  |
|       |

# INCIDENT SUMMARY Continued

|  |
| --- |
| Please provide a comprehensive summary of what occurred (additional space): |
|       |

**Please fill in an “X” if any emergency services were called:**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  **POLICE** | [ ]  **FIRE** | [ ]  **AMBULANCE** | [ ]  **No Emergency Services Called** |

# WITNESS INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Witness Name: |       | Witness Phone Number: |       |
| Witness Address: |       | Witness Email: |       |

# ADMIN FOLLOW-UP

|  |  |  |  |
| --- | --- | --- | --- |
| Injured Party/Victim Contacted: | [ ]  Yes [ ]  No | Date Contacted:(YYYY-MM-DD) |       |
| Witness Contacted: | [ ]  Yes [ ]  No | Date Contacted:(YYYY-MM-DD) |       |

Copy of report forwarded to:

|  |  |  |
| --- | --- | --- |
| [ ]  Director of Operations | [ ]  Chief Executive Officer | [ ]  N/A |

|  |
| --- |
| Additional Follow-Up/Information (if needed): |
|       |