Assurances Bernier & Filles

INCIDENT REPORT

☆ SEND THIS FORM TO: info@abernier.ca

INCIDENT DATE:/ CUSTOMEF	R NUMBER:	CUSTOM	IER CODE:		
BC / CPE / DAYCARE / REGROUPEMENT:				-	
FULL ADRESS:					
PHONE NUMBER:					
DIRECTOR / COORDINATOR/PROVIDER:					**
INJURED :	DATE OF BIRTH:_	/	/		
PARENT:					77
FULL ADRESS:					_ 11
PHONE NUMBER:					
PERSON CONTACTED:	DATE:	//_		TIME:	
SCENE OF THE INCIDENT:					
NAME OF PROVIDER IN CHARGE AT THE TIME OF THE INC	CIDENT:				
DESCRIBE AND INDICATE THE INJURY (IES):	5.02.111.				
IMMÉDIATE MEASURES (FIRST AID) :					
IMMEDIATE MEASURES (FIRST AID) .					
TRANSPORTATION TO HEALTH SERVICES : OUI NON					
NAME OF HOSPITAL:	_				
ADRESS:					
EXAMINED AT EMERGENCY: OUI \(\square\) NON \(\square\) HOSPITALI					
WITNESS 1. NAME)	
WITNESS 2. NAME)	
I (PARENT/GUARDIAN) ACKNOWLEDGE HAVING BEEN IN	FORMED OF THE INCIDEN	NT AS DESCI	RIBE IN THIS	S DOCUMEN	IT.
SIGNATURE	DATE:	/_	/_		
PARENT/GUARDIAN					
SIGNATURE	DATE:	/_	/_		
SIGNATURE DIRECTOR / COORDINATOR/PROVIDER					

These procedures, policies, job offers and processes are the exclusive property of Assurances Bernier & Filles and the disclosure of these, in whole or in part, is strictly prohibited without its express authorization

