

BGDA Incident Report Form

I AM REPORTING A BGDA EVENT-RELATED:	<input type="checkbox"/>	INJURY	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>	OTHER SITUATION
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REPORTER'S NAME:	BGDA PRESIDENT'S NAME:
<input type="text"/>	<input type="text"/>

REPORTER'S POSITION TITLE:	DATE OF REPORT:
<input type="text"/>	<input type="text"/>

LOCATION OF INCIDENT:	DATE OF INCIDENT:	TIME:
<input type="text"/>	<input type="text"/>	<input type="text"/>

WITNESSES *if any*:

INCIDENT DESCRIPTION *Describe what occurred in the situation:*

WAS MEDICAL TREATMENT REQUIRED?		IF YES, DETAILS OF TREATMENT	
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
<input type="text"/>			

RECOMMENDATIONS *Could anything have been done to prevent the incident?*

REPORTER'S SIGNATURE	DATE	BGDA PRESIDENT'S SIGNATURE	DATE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

