Critical Incident Form

Part A

Details of the person completing the form	Name			
	Phone no:			
	Email:			
Date and Time of the incident				
Location of the incident				
Brief description of the incident	Type of Incident:			
	Description of Incident:			
Name and contact details for witnesses to The incident				
Was anyone injured?	No (Complete Part C)		Yes (Complete Part B)	

Part B

Details of the Injured Person	Name	
	Gender	☐ Male ☐ Female ☐ Other
	Date of Birth	
	Contact details	
	Emergency contact details	
Description of the injury		
Treatment required	☐ No ☐ First Aid ☐ Doctor ☐ Hospital admission ☐ Other, please specify	

Part C

Description of the Damage	
Were there any other services involved/ attended? (If yes, attach a copy of the report)	

Person/s involved:

Name	Contact number	Address

Recommended actions taken by FCA

Sign:	**Date:**