



# Incident Report Form

Use this form to report accidents, injuries, medical situations, or child behavior incidents. (Incidents involving a crime or traffic incident should be reported directly to the Shawano City Police Dept.) If possible, the report should be completed within 24 hours of the event. Submit completed forms to the SHL President.

| INFORMATION ABOUT PERSON INVOLVED IN THE INCIDENT |                                     |                                  |      |
|---|-------------------------------------|----------------------------------|------|
| Full Name   |                                     |                                  |      |
| Home Address                                      |                                     |                                  |      |
|   | <input type="checkbox"/> SHL Member | <input type="checkbox"/> Visitor |      |
| Phone Numbers                                     | Home                                | Cell                             | Work |

| INFORMATION ABOUT THE INCIDENT  |      |  |
|---|------|--|
| Date of Incident  | Time | Police Notified <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Location of Incident (ice rink, lobby, bathroom, ect....)   |      |  |
| Description of Incident (what happened, how it happened, factors leading to the event, etc.) Be as specific as possible (attached additional sheets if necessary)   |      |  |
| Were there any witnesses to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, attach separate sheet or write on back. names, addresses, and phone numbers.  |      |  |
| Was the individual injured? If so, describe the injury (laceration, sprain, etc.), the part of body injured, and any other information known about the resulting injury(ies).   |      |  |
| Was medical treatment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused<br>If yes, where was treatment provided: <input type="checkbox"/> on site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other |      |  |

| REPORTER INFORMATION                      |
|---|
| Individual Submitting Report (print name) |
| Signature                                 |
| Date Report Completed                     |

**FOR SHL BOARD USE ONLY**

Report Received by \_\_\_\_\_

Date \_\_\_\_\_