INCIDENT REPORT

Department: ____________________________  Building: ____________________________
Group: ____________________________  Completed by: ____________________________
Completed by: ____________________________  Telephone: ____________________________

- Biological accident  - Fire  - Sharp objet or cut
- Chemical accident  - Explosion  - Other
- Physical accident  - Pressurized gas
- Radiation accident  - Product leak or spill
- Other

Date: ____________________________  Time: ____________________________
Location / Set-up: ____________________________

Product: ____________________________

Incident description:

Sketch / Diagram (if necessary):

Causes: ____________________________
People affected:

**Damages:** (people, property, environment)

**Approximate cost of material damage:**

**Consequences:** (ex. work leave)

**Immediate actions:**

**Long-term actions:**

**Complementary report will be completed:**  
- Yes  
- No

**Internal or external calls:**

- Emergency services
- 115
- Safety services (UNISEP)
- Technical services (UNIBAT)
- Other: ....................

**Signature, date:**

Submit to Occupational Health and Safety Services via the department safety coordinator