





**Please only complete the next section if this incident resulted in injury.**

Brief description of injuries sustained:

Did the injured person(s) need to attend hospital?  Yes  No

If you answered "Yes" to the previous question, please provide the following details:

Name of hospital:  Ward No:

Time of admission:  Time of discharge:

Date of admission:  Date of discharge:

Was an ambulance called to the incident?  Yes  No

If yes, please provide details of the person who called the ambulance:

Name:  Phone:

Were Police involved in the incident?  Yes  No

If yes, is a copy of the Police Report attached?  Yes  No

If there were no Police involved and a Police Report cannot be provided, please attach an additional page/pages with a full description of the incident including a summary of events prior to the incident.

**Declaration:**

I, ,  declare that all  
(FULL NAME) (Date of Birth)  
information provided in this report is true and correct to the best of my knowledge.

Signed:  Date:

**Office Use Only**

Response/Action made to date: *(if no action has been taken, please state why)*

Completed By:  Position:

Signed:  Date:

**Document Information**

|                  |  |                       |                |
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| <b>Title:</b>    | F.07V03 Critical Incident Initial Report Form    | <b>Version No:</b>    | V3.0           |
| <b>Reviewer:</b> | Administration                                   | <b>Date Created:</b>  | 1 January 2018 |
| <b>Address:</b>  | Level 1, 377 Lonsdale Street, Melbourne VIC 3000 | <b>Reviewed Date:</b> | 20 May 2024    |