



Incident Threshold Level: I II III IV V

Incident Number: -

SCC INCIDENT REPORT FORM

Region:

Crew Number:

Name of Person Involved:

Participant Crew Leader Staff

Incident occurred:

Date

Time

Area/location of incident:

Backcountry Front Country

Name(s) of Crew Leader(s):

Name of Person Completing Report:

Report completed:

Date

Time

Was this a Near Miss/Safety Flag?

"Yes

No

Were SCC policies, procedures and protocols being followed at the time of the incident? Yes

No

If No, Explain below:

Type of Injury:

- Abrasion
- Contusion
- Laceration
- Puncture
- Sunburn
- Burn (non-sun)
- Blister
- Bug Bite(s) Kind:
- Sting(s) Kind:
- Rash from Plants:
- Sprain or Strain
- Head (conscious)
- Head (unconscious)
- Dislocation
- Fracture Bone:
- Other:

Type of Illness:

- Gastrointestinal
- Abdominal Pain
- Diarrhea
- Respiratory Systems
- Allergy
- Infection
- Flu Symptoms
- Tick Related
- UTI
- Fever
- Dehydration
- Heat Exhaustion
- Hypothermia
- Altitude
- Other:

Behavioral:

- Motivation
- Drugs/Alcohol/Tobacco
- Psychological
- Verbal/Physical Harassment
- Safety/Judgment
- Sexual Harassment
- Other:

Other:

- Travel Problems
- Family Emergency
- Vehicle Accident
- Property Damage
- Other:

Program Activity:

- Hiking (w/o pack)
- Hiking to Worksite
- Camping
- Canoeing
- Cooking
- Swimming
- Driving
- Free-time/Recreation
- Group Initiatives
- Kitchen/Dishes
- Other Camp Activity
- Work Project:
 - Sharpening
 - Moving rock/timber
 - Tool/Kind:
 - Chainsaw work
- Other:

Will this be a Worker's Comp Claim? Yes No **If yes, complete WC Form and report**
Is this a vehicle accident/incident? Yes No **If yes, complete the VAF**
Is this a significant medical incident? Yes No **If yes, complete a SOAP note**

Narrative of Incident (Include names, dates, times, locations, damages, injuries – attach additional pages if necessary)

What is the Plan of Action/Future Steps?

Have parents/emergency contacts been notified: Yes No **By Whom?**

Did the patient leave the field at any time? Yes No

Will the patient return to the field to complete the program? Yes No

If yes, when?

If not, why?

Due to Illness/Injury Dismissed by Crew Leaders/Staff Voluntarily

Incident Status (PD Only): On-Going Closed (Date "****")

For Risk Management Use:

Incident Needs to be Reviewed: Yes No

Incident Reviewed By: _____ Date: _____

Program Days lost due to Illness/Injury: _____ Program Days Lost due to Behavioral Issues: _____

Contributory Causes (rate 1,2,3, etc.):

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Unfit | <input type="checkbox"/> Failed to Follow Instructions | <input type="checkbox"/> Experience |
| <input type="checkbox"/> Weather | <input type="checkbox"/> Falling Object | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Animal | <input type="checkbox"/> Pre-Existing Condition | <input type="checkbox"/> Slip/Fall |
| <input type="checkbox"/> Missing/Lost | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Darkness | <input type="checkbox"/> Clothing | <input type="checkbox"/> Hydration |
| <input type="checkbox"/> Distraction | <input type="checkbox"/> Equipment | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Equipment Failure | <input type="checkbox"/> Instruction/Training | <input type="checkbox"/> Misbehavior |
| <input type="checkbox"/> Exceeded Ability | <input type="checkbox"/> Supervision | <input type="checkbox"/> Other: |