

BBC Occupational Risk Management arrangements require that this Form is completed by the Person in Charge as soon after the Incident as possible and be a true and accurate statement of what happened.

INCIDENT DATE	INCIDENT TIME	REPORT DATE	REPORT TIME

INCIDENT OWNERSHIP		
DIVISION	SUB-DIVISION	UNIT OR DEPT

DESCRIPTION OF WHAT HAPPENED			

EXACT INCIDENT LOCATION			
On or Off BBC Site	Region/Area	Location	Sub-Area

PERSON INVOLVED

Does the person consent to details of their involvement in this Incident being passed to their union rep?	Yes / No
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CATEGORY OF PERSON <input checked="" type="checkbox"/>					
Employee	<input type="checkbox"/>	Contractor	<input type="checkbox"/>	Freelance	<input type="checkbox"/>
Artist/Contributor	<input type="checkbox"/>	Mem of. Public	<input type="checkbox"/>		

NATURE OF INVOLVEMENT <input checked="" type="checkbox"/>			
Witness	<input type="checkbox"/>	First Person on Scene	<input type="checkbox"/>
Other	<input type="checkbox"/>		

PERSON'S NAME			
Name:	Mr/Mrs/Miss/Ms	First Name:	Last Name:

OTHER INFORMATION

NATURE OF CALL <input checked="" type="checkbox"/>							
Fire	<input type="checkbox"/>	Dust	<input type="checkbox"/>	Faulty Equipment	<input type="checkbox"/>	Effects	<input type="checkbox"/>
Hot Work	<input type="checkbox"/>	Maintenance	<input type="checkbox"/>	Toast or kitchen-related	<input type="checkbox"/>	Smoking	<input type="checkbox"/>
Suspect Device	<input type="checkbox"/>	False Alarm	<input type="checkbox"/>	Accidental Glass Break	<input type="checkbox"/>	Power Cut	<input type="checkbox"/>
Miscellaneous Security Incident				Other Type of Incident			

ALARM ACTIVATION TYPE	Gas System / Vesda
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MODE OF CONTACT <input checked="" type="checkbox"/>			
Call to 666 or Security	<input type="checkbox"/>	Alarm Activation	<input type="checkbox"/>
Break Glass or Call Point	<input type="checkbox"/>	Other	<input type="checkbox"/>
If "Other" please specify:			

REPORTING <input checked="" type="checkbox"/>			
Actual Fire	<input type="checkbox"/>	Evacuation	<input type="checkbox"/>
Fire Brigade Attended	<input type="checkbox"/>	Broadcast Affected	<input type="checkbox"/>

Time Fire Service called	
Time Fire Service attended	
Time event concluded	

INCIDENT REPORTED BY		
Name	Telephone No.	Date