



Critical Incident Report Form

1. Incident Overview

Field	Details
Date of Incident	___ / ___ / 20___
Time of Incident	_____ AM / PM
Location of Incident	<input type="checkbox"/> On Campus <input type="checkbox"/> Off Campus <input type="checkbox"/> Online
Reported By (Name)	
Role	<input type="checkbox"/> Staff <input type="checkbox"/> Student <input type="checkbox"/> Other: _____
Contact Number	
Immediate Actions Taken	<input type="checkbox"/> First Aid <input type="checkbox"/> Emergency Services Called <input type="checkbox"/> Incident Contained <input type="checkbox"/> None

2. Individuals Involved

Full Name	Student ID / Staff Role	Contact Info	Involvement
			<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Responder
			<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Responder



Full Name	Student ID / Staff Role	Contact Info	Involvement
			<input type="checkbox"/> Victim <input type="checkbox"/> Witness <input type="checkbox"/> Responder

3. Incident Type (Tick all that apply)

- Death or serious injury
- Physical or sexual assault
- Mental health crisis (e.g., suicide attempt)
- Threat of harm / violence
- Drug or alcohol incident
- Missing person
- Natural disaster
- Fire or explosion
- Other: _____

4. Incident Description

Please describe the event in detail, including sequence of events, observed behaviours, and any contributing factors:

5. Initial Support and Safety Actions

Action	Performed By	Notes
<input type="checkbox"/> First Aid Administered		
<input type="checkbox"/> Emergency Services Contacted	<input type="checkbox"/> Police <input type="checkbox"/> Ambulance <input type="checkbox"/> Fire	
<input type="checkbox"/> Family / Emergency Contact Notified		



Action	Performed By	Notes
<input type="checkbox"/> Immediate Counselling Provided		
<input type="checkbox"/> Evacuation Conducted		
<input type="checkbox"/> Site Secured		

6. Follow-Up Plan

Task	Assigned To	Due Date	Completed
Referral to external support services			<input type="checkbox"/>
Academic adjustments required			<input type="checkbox"/>
Family engagement or debriefing			<input type="checkbox"/>
ASQA Notification (if required)			<input type="checkbox"/>
Add to Continuous Improvement Register			<input type="checkbox"/>

7. Compliance and Recordkeeping

Field	Details
Report Received By	(Compliance Manager Name)
Date Received	___ / ___ / 20___
Secure File Location	_____
Incident Number	CI-___-20
Retention Schedule	Minimum 2 years post-enrolment



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8. Authorisation

Name	Signature	Date
Reporting Staff		
Compliance Manager		
CEO (if escalated)		