

CRITICAL INCIDENT REPORT

Office Use Only CUSTOM CONVENTIONAL PROJECT # _____ BUS No. _____
 COLLISION PASSENGER INJURY SECURITY WITNESS OTHER _____ ICBC No. _____

Reports must be submitted within 24 hrs of accidents/incidents

Use ink and fill in **all** applicable boxes

A. Complete this section for all ACCIDENTS / INJURIES / SECURITY

Incident Information

DAY / MONTH / YEAR / /	DAY OF WEEK	TIME	ROUTE	VEHICLE NO.	LICENSE PLATE NO.	DRIVERS LICENSE NO.	HRS WORKED PRIOR TO INCIDENT:
E - SENIORITY NO.		LAST NAME		FIRST NAME			
LOCATION ON: AT/BETWEEN:					CITY / TOWN		

Vehicle Involved

Bus (Operator) Bus (Maintenance) Service Vehicle Equipment/Property
 Bus (Training) Supervisor Vehicle Pool Car Other _____

Experience with vehicle/equipment: _____ MONTHS _____ YEARS

Vehicle load: Empty (driver only) Seated load Some standees Crowded Estimated # of passengers: _____

Reports and Assistance

Supervisor:	CALLLED <input type="checkbox"/> YES <input type="checkbox"/> NO	ATTENDED <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME
Law Enforcement:	ATTENDED <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME	BADGE NO. DETACHMENT
	REPORT/CASE NO.	TICKET(S) ISSUED <input type="checkbox"/> Operator <input type="checkbox"/> Motorist <input type="checkbox"/> Passenger	CHARGE

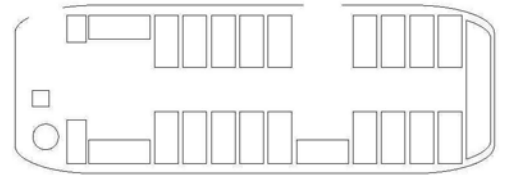
Continue to section B for ACCIDENTS/INJURIES, C for SECURITY, then section D for all (or witness only)

B. Complete this section for all ACCIDENTS / INJURIES

Accident/Injury Information

Vehicle Movement		Vehicle Stationary		Weather (describe)
Bus (OTHER VEHICLE)	Bus (OTHER VEHICLE)	Bus (OTHER VEHICLE)	Bus (OTHER VEHICLE)	
<input type="checkbox"/> Straight ahead	<input type="checkbox"/> Skidding	<input type="checkbox"/> Legally parked	<input type="checkbox"/> Illegally parked	
<input type="checkbox"/> Passing	<input type="checkbox"/> Wrong side	<input type="checkbox"/> Stopped in traffic	<input type="checkbox"/> Stopped in zone	
<input type="checkbox"/> Being passed	<input type="checkbox"/> Starting	<input type="checkbox"/> Stopped in zone	<input type="checkbox"/> Other	Speed _____ KM/h
<input type="checkbox"/> Turning	<input type="checkbox"/> Stopping			Delay at Scene _____ MINUTES
<input type="checkbox"/> From curb/zone	<input type="checkbox"/> Changing speed			
<input type="checkbox"/> Into curb/zone	<input type="checkbox"/> Changing lanes			
<input type="checkbox"/> Weaving	<input type="checkbox"/> Other			

Mark "X" on bus where damaged, where passenger injured, or where incident occurred



ACCIDENTS

Collision Type

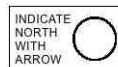
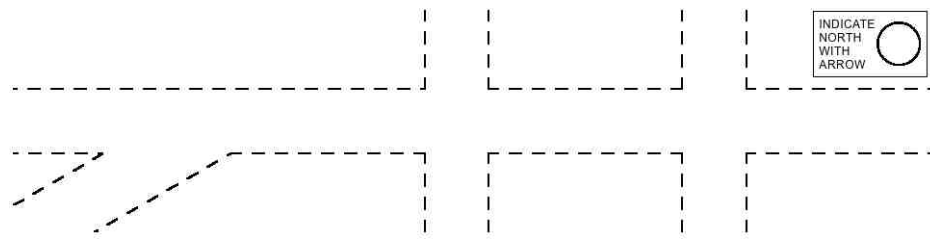
Between Vehicles <input type="checkbox"/> Rear end other bus <input type="checkbox"/> Other bus rear ends <input type="checkbox"/> Collision in yard <input type="checkbox"/> Pulling out of yard <input type="checkbox"/> Pulling into yard <input type="checkbox"/> Other	Oncoming <input type="checkbox"/> Head on <input type="checkbox"/> Vehicle contacts <input type="checkbox"/> Bus contacts vehicle <input type="checkbox"/> Vehicle making turn <input type="checkbox"/> Bus making turn Vehicle Ahead/Behind <input type="checkbox"/> Bus rear ends vehicle <input type="checkbox"/> Vehicle rear ends Bus <input type="checkbox"/> Bus reverses into vehicle <input type="checkbox"/> Vehicle reverses into Bus	Intersections <input type="checkbox"/> Bus turns into vehicle <input type="checkbox"/> Vehicle turns into Bus Other Collisions <input type="checkbox"/> Cluster lamp <input type="checkbox"/> Bus stop/exchange <input type="checkbox"/> Other fixed object <input type="checkbox"/> Bicycle <input type="checkbox"/> Animal <input type="checkbox"/> Other
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Collision Factors

Distance and Speed			
	Prior	At contact	Travel distance after
Bus:	_____ KM/h	_____ KM/h	_____ METRES
Oth Veh:	_____ KM/h	_____ KM/h	_____ METRES
Dist. of vehicle/pedestrian when in danger: _____ METRES			
Vehicle Lights	<input type="checkbox"/> ON <input type="checkbox"/> OFF	<input type="checkbox"/> ON <input type="checkbox"/> OFF	
Travel Direction	<input type="checkbox"/> North <input type="checkbox"/> East <input type="checkbox"/> South <input type="checkbox"/> West	<input type="checkbox"/> North <input type="checkbox"/> East <input type="checkbox"/> South <input type="checkbox"/> West	
Signals	<input type="checkbox"/> Horn <input type="checkbox"/> Signal <input type="checkbox"/> Hands <input type="checkbox"/> 4-ways	<input type="checkbox"/> Horn <input type="checkbox"/> Signal <input type="checkbox"/> Hands <input type="checkbox"/> 4-ways	

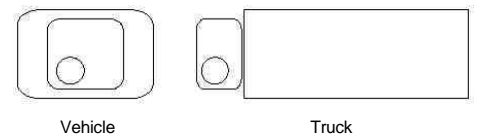
Damage

TRANSPORTATION VEHICLE	OTHER VEHICLE



Draw sketch of incident site showing roads, curbs, obstructions, traffic lights, vehicles, pedestrians, etc. and indicate vehicle direction with arrows.

Mark "X" on vehicle / truck where it was struck or damaged:



Other Vehicle / Property

DRIVER'S FAMILY NAME	GIVEN NAME	AGE (EST.) OR D.O.B.	DRIVER'S LICENSE	D. LIC. PROV. OR STATE
DRIVER'S ADDRESS		VHE. LIC. NO.	LIC. PROV. OR STATE	VEHICLE YEAR, MAKE, MODEL
DRIVER'S PHONE NO.	INSURED BY (ONLY OUT OF PROV. VEH.)		PROPERTY DAMAGE	
OWNER'S FAMILY NAME	GIVEN NAME	OWNER'S ADDRESS	OWNER'S PHONE NO.	

Injuries on board other vehicle? YES NO **If so, fill out INJURIES section (next), if not continue to section D**

