

TRACER

SECURITY SERVICES

INCIDENT REPORT Tfor027 Revision 5/3/10

Site Information

Site Name: _____ Date: _____

List Attachments: _____

What Happened (Choose all that apply)

<input type="checkbox"/> Assault	Describe Below
<input type="checkbox"/> Complaint	Describe Below
<input type="checkbox"/> Fall	Where did the fall happen: _____ Footwear: <input type="checkbox"/> Rubber Sole <input type="checkbox"/> Sandals <input type="checkbox"/> Other: _____ <input type="checkbox"/> Leather Sole <input type="checkbox"/> Slippers Weather Conditions (if outside): <input type="checkbox"/> Sunny <input type="checkbox"/> Raining <input type="checkbox"/> Windy Ground Conditions <input type="checkbox"/> Dry <input type="checkbox"/> Damp <input type="checkbox"/> Puddles Floor Conditions (if inside) <input type="checkbox"/> Dry <input type="checkbox"/> Liquid Spill <input type="checkbox"/> Solid Debris <input type="checkbox"/> Offered First Aid (if trained) <input type="checkbox"/> Refused First Aid <input type="checkbox"/> EMS Notified Time: _____ <input type="checkbox"/> N/A
<input type="checkbox"/> Fire	Where was the fire Observed? _____ Fire Department Called? <input type="checkbox"/> Yes Time: _____ <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Disruptive Behavior	Police called for assistance? <input type="checkbox"/> Yes Time: _____ <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Missing Property or Theft	List all missing items below
<input type="checkbox"/> MVA	Police Department called? <input type="checkbox"/> Yes Time: _____ List all vehicles and drivers involved below.
<input type="checkbox"/> Property Damage	Police Department called? <input type="checkbox"/> Yes Time: _____ Describe all reported damage below.
<input type="checkbox"/> Vandalism	Where was the vandalism Observed? _____ Police Department called? <input type="checkbox"/> Yes Time: _____ Describe all reported damage below.
<input type="checkbox"/> Threat of Violence	Threat to: <input type="checkbox"/> Yourself <input type="checkbox"/> Employee <input type="checkbox"/> Customer <input type="checkbox"/> Other: _____ Police Department called? <input type="checkbox"/> Yes Time: _____
<input type="checkbox"/> Bomb Threat	Date of Call: _____ Time of Call: _____ Caller's Name (if given): _____ Telephone #: _____ Site Manager Notified Date: _____ Time: _____ Police Notified Date: _____ Time: _____

__ Other

Describe Below

Describe What Happened. (State the facts only, no opinions. Include any statements made by customers, employees or any other individual who was involved are witness the event)

Your Actions Taken

Persons Completing Report

Title	Last Name	First Name	Date:	Time

Signature

Report Processed Through Chain-Of-Command

Site Manager

Title	Last Name	First Name	Date:	Time

Signature

Corporate Manager

Title	Last Name	First Name

Signature