

Incident Report Form



The Commonwealth of Massachusetts
Division of Capital Asset Management & Maintenance
Office of Facilities Management & Maintenance
 1 Ashburton Place
 Boston, Massachusetts 02108
 617 727-1000

Please fill in applicable space on Page 1 and provide narrative information on Page 2. Completed reports should be promptly submitted to the Director of Security, Division of Capital Asset Management and Maintenance

Date of Incident:	Time of Incident:	Day of Week:
Date of Report:	Report by:	
Location (Specific):		

Type of Incident:	Injury	<input type="checkbox"/>	Security Issue	<input type="checkbox"/>	Threat	<input type="checkbox"/>
<i>Check all that apply</i>	Fire	<input type="checkbox"/>	MV Accident	<input type="checkbox"/>	Assault	<input type="checkbox"/>
	Theft	<input type="checkbox"/>	Vandalism	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>

Involved Party:	Telephone #:	Ext.#
Agency?:	Visitor:	Witness:
Witness 1:	Telephone #:	Ext.#
Witness 2:	Telephone #:	Ext.#

Injuries? (Y/N)	Description of Injuries (specific):
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Police/Fire/EMS Notified?	Person Notified:
BSB Staff Notified?	Person Notified:

Complaint against (if applicable):		Agency/Visitor:	
Sex:	Male <input type="checkbox"/>	Race:	_____
	Female <input type="checkbox"/>	Height:	_____
		Age:	_____
		Eye Color:	_____
Other Identifiers:			

Date Received:	Referred to:	Date:
Comments:		
Completed by:		

See additional pages for Incident Report Narrative/Information and After Action Report (if applicable).

INCIDENT # _____
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SPRINGFIELD STATE OFFICE BUILDING



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INCIDENT REPORT FORM
NARRATIVE OF EVENTS/INCIDENT

Narrative submitted by: _____ **Date:** _____

See additional pages for Incident Report Narrative/Information and After Action Report (if applicable).

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INCIDENT REPORT FORM
AFTER ACTION REPORT

This page is to be completed by Division of Capital Asset Management and Maintenance personnel.



EVENT

RESPONSE

COMMENTS

RECOMMENDATIONS/ACTION

Submitted by:	Date:
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INCIDENT # _____
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