



All incidents must be reported to SCM/Claimspro

Phone: 1-844-849-5097 (Local: 416-933-5210), Fax: 1-888-893-TIMS (8467), Email: timhortons@scm.ca

INCIDENT REPORT FORM

After Hours Reporting: **Claimspro** 1-888-512- TIMS (8467)

RESTAURANT INFORMATION (must be completed for **ALL** incidents)

Restaurant No:	Restaurant Owner:	Manager On Duty:		
Address:		City:	Province:	Postal Code:
Name of Employee Completing Form:		Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Restaurant Owner Tel: (____)		Restaurant Owner E-Mail/Other:		
Date of Incident: _____		Time: _____	Date Reported to Manager/Owner: _____	

GUEST INFORMATION

Name:	Male/Female:		
Address:	City:	Province:	Postal Code:
Residence Tel: (____)	Alternate Tel: (____)		
Describe the Incident/Nature of Guest Injury:			

Where Did Incident Happen? If In Restaurant: Counter Area: _____ Dining Area: _____ Entranceway: _____ Washroom: _____
If in Another Area of Premises: Drive -Thru: _____ Parking Lot: _____ Sidewalk: _____ Other: _____
Description of Injury/Property Damage: _____

Surveillance Coverage: ☐ Yes ☐ No Was picture taken of the accident area? ☐ Yes ☐ No If "Yes", include surveillance and photos.
Product involved: _____ Where is it? _____

Was medical treatment provided: ☐ Yes ☐ No Declined: _____
If "Yes", treatment provided by: Ambulance : _____ Fire Dept: _____ Police: _____ Doctor: _____ Other: _____
Describe treatment, if possible: _____

For "Slip & Fall": If in restaurant, were "Wet Floor" signs used? : ☐ Yes ☐ No Where were they positioned? _____
State of area where fall occurred (wet, dry freshly mopped, rain-soaked, icy, snow-covered, etc.) _____
Weather conditions at time of fall? _____ Type of Shoes Worn by Guest: _____

Witness Name:	Tel: (____)	Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
Witness Name:	Tel: (____)	Statement Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No

Reported to police? ☐ Yes ☐ No If "Yes" Name, Badge, Division: _____ Occurrence No. _____
Charges Laid? ☐ Yes ☐ No If "Yes" what charges _____

RESTAURANT OWNER PROPERTY DAMAGE / BUSINESS INTERRUPTION / EMPLOYEE THEFT INFORMATION

Description of Property Damage/Stolen Goods: _____ Estimated Amount (\$): _____
Where and how did incident happen? _____
Name of driver causing damage: _____ Driver's Lic. No: _____
Owner's Name (if different from driver): _____
Street Address: _____ City: _____ Province: _____ Postal Code: _____
Vehicle Information: Year, Make, Model: _____ Lic. Plate No. _____ Colour: _____
Insurance Co./Broker: _____ Policy No. _____
If Cash Loss: Stolen From Safe: _____ Stolen From Cash Drawer: _____ Other (briefcase, vehicle, etc.): _____

This form is to be completed by Person in Charge.

This form is for internal record keeping purposes only and should be kept in a file for future reference. Not for distribution to public.