**Incident Report Form**

**Section 1: Assessment Details** *(to be completed by the Invigilator/ Assessor)*

|  |  |  |
| --- | --- | --- |
| **Type of qualification** | | |
| Speech ☐ | ESOL SfL ☐ | ESOL International ☐ |

|  |  |
| --- | --- |
| **Assessment information - complete all sections which are appropriate to the assessment** | |
| Type of assessment (e.g. Written/ Speaking) |  |
| Assessment form (online/face-to-face) |  |
| Level of assessment (e.g. B1/ B2 or E3, L1, etc.) |  |
| Date of assessment |  |
| Start time of assessment |  |
| End time of assessment |  |
| Time of incident |  |
| Centre/ Satellite Centre/ Venue name |  |
| Centre/ Satellite Centre/ Venue ID |  |
| Assessor / Invigilator name |  |
| Quality Assurance Organiser / Centre contact name |  |

**Section 2: Incident Details**

|  |  |
| --- | --- |
| **Tick all which are appropriate to the incident which has occurred** | |
| Learner issue | ☐ |
| Disruption (e.g – Noise, Interruption) | ☐ |
| Administration error (e.g – Photocopies, Missing papers, Incorrect paper used) | ☐ |
| Equipment (e.g – Audio equipment) | ☐ |
| Assessment room | ☐ |
| Other |  |

|  |
| --- |
| **Nature of incident** |

**Section 3: Learners Affected**

|  |  |  |
| --- | --- | --- |
| **Were any learners affected by the incident?** | Yes ☐ | No ☐ |
| **If Yes – List affected learners’ names (& IDs below)** | | |
| **If Yes – Explain how learner(s) were affected** | | |

|  |  |  |
| --- | --- | --- |
| **Was the incident resolved at the time of the assessment?** | Yes ☐ | No ☐ |
| **If Yes – Explain how the matter was resolved** | | |

**Section 4: Declaration**

|  |
| --- |
| **Incident Report Form completed by:** |
| Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |