

INCIDENT/COMPLAINT REPORT

EMPLOYEE: Return this COMPLETED FORM to your SUPERVISOR as soon as possible.

Name of Person Involved:

Address:

City:

Phone Number:

Age:

DOB:

SS#:

Date of Incident:

Time:

Exact Location of Incident:

Check Type of Accident:

Check:

Clerical/Data Entry

Patient

Communications

Employee

Testing Process

Visitor

Result Reporting

Volunteer

Safety

Other

Medical Device Failure

Policy/Procedural Violations

Adverse Drug Reaction

Vehicle Accident

Needlestick

Exposure to Hazardous Substance

Medication Error (Wrong: Route, Dosage, Medication, Schedule)

EMPLOYEE: Involved Yes No

Were they doing their regular job duties: Yes No Observed by employee: Yes

Hire Date: Marital Status: Situation observed only by employee Yes

Employee Classification:

Protective Equipment being used: Yes No

If not used, why:

Description of Incident/Complaint (Who, What, Where, How, Why, Include sequence of events, personnel involved, body part injured, reason incident occurred) (If medication error include brand name, manufacturer, dosage) (Use additional form if necessary)

Actions Taken by Staff Members:

Witness Name:

Phone Number:

Address:

MEDICAL FOLLOW-UP: Was medical attention sought:

Yes

No

Treatment Refused:

Yes

No

First Treatment Date:

Treatment Physician

Phone Number:

Address:

First Day Off Work:

Return to Work Date:

Duties Restricted:

Yes

No

Explain: