

Appendix E

INCIDENT REPORT FORM

Department:		Unit/Specialization:	
Location:		Date/Time of Incident:	
Names of Involved:			
ID Numbers:			
Incident Description:			

INJURED PERSON AND MEDICAL STATUS			
Was anyone Injured during the incident?			
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Staff	<input type="checkbox"/>	Student
<input type="checkbox"/>		<input type="checkbox"/>	Visitor
Was first aid administered?			
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Was the person treated in the clinic?			
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Was the person hospitalized?			
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

PROPERTY AND EQUIPMENT	
Was any equipment compromised?	
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
Equipment Details and RC numbers:	
Property Status? <input type="checkbox"/> Damaged <input type="checkbox"/> Repairable <input type="checkbox"/> Unrepairable	
WHAT WAS THE PRIMARY CAUSE OF THIS ACCIDENT?	
Describe:	

RECOMMENDATIONS TO PREVENT SIMILAR ACCIDENTS

Describe:

Is additional training/coaching needed?

Are amendments required in work procedures?

Is a work order needed to correct a hazard?

Name(s) of Person/Team Completing this Report:

Date: