INCIDENT REPORT - EMPLOYEE/VISITOR

PERSON INVOLVED (Last name) (First name) (Middle initial) ❍ Male ❍ Female Age _____

Date of incident | Time of incident ❍ AM ❍ PM | Exact location of incident: ❍ Agency office ❍ Patient/Client residence ❍ Other, specify:

❍ EMPLOYEE | Department | Job title

❍ VISITOR ❍ OTHER | Home address | Home phone

Occupation | Reason at location | Was person authorized to be at location of incident? ❍ Yes ❍ No

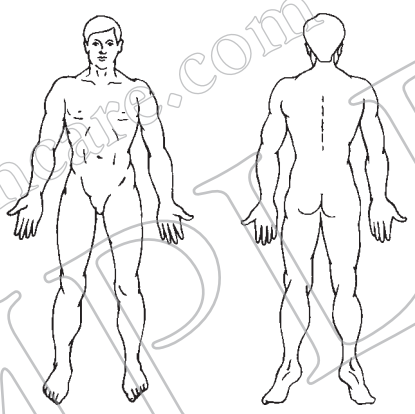
INCIDENT TYPE:

- ❑ Fall
- ❑ MVA
- ❑ Sprain/Strain
- ❑ Exposure to blood/body fluid
- ❑ Needle stick
- ❑ Exposure to COVID-19
- ❑ Exposure to other respiratory hazard:_____
- ❑ Animal bite
- ❑ Assault
- ❑ **EQUIPMENT/MEDICAL DEVICE:**
  - Type:_____
  - Vendor:_____
- ❑ **OTHER:**
  - _____
  - _____
  - _____
  - _____

❑ **NO INJURY** **TYPE OF INJURY:** ❑ Laceration ❑ Hematoma ❑ Abrasion ❑ Burn ❑ Swelling ❑ Pain ❑ None apparent ❑ Other, specify:

Location of injury:

Indicate on diagram location of injury.



VITAL SIGNS

Temp._____
HR_____
Resp._____
BP_____
❍ Lying ❍ Sitting ❍ Standing

LEVEL OF CONSCIOUSNESS

_____
_____
_____
_____

Describe exactly what happened; why it happened; what the causes were. Describe details of injury. If property or equipment damaged, describe damage.

Notification of physician/family/other Name | Time of notification ❍ AM ❍ PM | Time responded ❍ AM ❍ PM

Was person involved seen by a physician? ❍ No ❍ Yes If Yes, physician's name | Where | Date | Time ❍ AM ❍ PM

Was first aid administered? ❍ No ❍ Yes If Yes, type of care provided and by whom | Where | Date | Time ❍ AM ❍ PM

Was person involved taken to ER? ❍ No ❍ Yes If Yes, hospitalized? ❍ No ❍ Yes | Transported by whom | Facility | Date | Time ❍ AM ❍ PM

Legal counsel notified? ❍ No ❍ Yes

Witness(es) - Name, title (if applicable), address & phone number

Additional comments and/or steps taken to prevent recurrence:

SIGNATURE/TITLE/DATE	SIGNATURE/TITLE/DATE
Person Preparing Report	Reviewed by