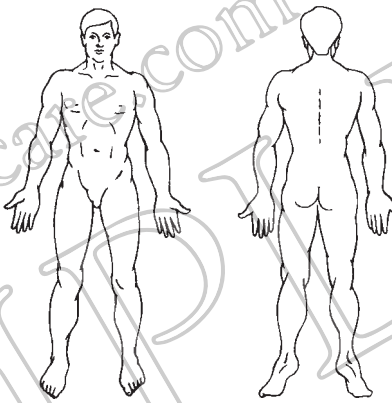


INCIDENT REPORT - EMPLOYEE/VISITOR

PERSON INVOLVED		(Last name)	(First name)	(Middle initial)	<input type="radio"/> Male <input type="radio"/> Female Age _____	
Date of incident	Time of incident <input type="radio"/> AM <input type="radio"/> PM	Exact location of incident: <input type="radio"/> Agency office <input type="radio"/> Patient/Client residence <input type="radio"/> Other, specify:				
<input type="radio"/> EMPLOYEE	Department			Job title		
<input type="radio"/> VISITOR <input type="radio"/> OTHER	Home address				Home phone	
	Occupation		Reason at location		Was person authorized to be at location of incident? <input type="radio"/> Yes <input type="radio"/> No	
INCIDENT TYPE:			<input type="checkbox"/> NO INJURY TYPE OF INJURY: <input type="checkbox"/> Laceration <input type="checkbox"/> Hematoma <input type="checkbox"/> Abrasion <input type="checkbox"/> Burn			
<input type="checkbox"/> Fall <input type="checkbox"/> MVA <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Exposure to blood/body fluid <input type="checkbox"/> Needle stick <input type="checkbox"/> Exposure to COVID-19 <input type="checkbox"/> Exposure to other respiratory hazard: _____ <input type="checkbox"/> Animal bite <input type="checkbox"/> Assault			<input type="checkbox"/> Swelling <input type="checkbox"/> Pain <input type="checkbox"/> None apparent <input type="checkbox"/> Other, specify: _____			
<input type="checkbox"/> EQUIPMENT/MEDICAL DEVICE:			Location of injury:			
Type: _____ Vendor: _____					VITAL SIGNS Temp. _____ HR _____ Resp. _____ BP _____ <input type="radio"/> Lying <input type="radio"/> Sitting <input type="radio"/> Standing	
<input type="checkbox"/> OTHER:					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 <input type="radio"/> AM <input type="radio"/> PM		Time responded <input type="radio"/> AM <input type="radio"/> PM
Was person involved seen by a physician? <input type="radio"/> No <input type="radio"/> Yes If Yes, physician's name			Where		Date	Time <input type="radio"/> AM <input type="radio"/> PM
Was first aid administered? <input type="radio"/> No <input type="radio"/> Yes If Yes, type of care provided and by whom			Where		Date	Time <input type="radio"/> AM <input type="radio"/> PM
Was person involved taken to ER? <input type="radio"/> No <input type="radio"/> Yes		Transported by whom	Facility		Date	Time <input type="radio"/> AM <input type="radio"/> PM
If Yes, hospitalized? <input type="radio"/> No <input type="radio"/> Yes						
Legal counsel notified? <input type="radio"/> No <input type="radio"/> 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		