INCIDENT REPORT

(All boxes are to be checked for response, click to initiate check mark, if N/A or discrepancies leave blank and fill in comments)

This form is to report and record incident details of an unusual event, complaint or compliment.

Facility Information:

Facility:_____ Phone Number:_____
Address:_____ City:_____State:_____Zip:_____
Employee Completing Report:_____ Department:_____

Personal Information

Name:_____ Age:_____ Gender:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone Number: Home:_____ Cell:_____ Work:_____
Family / Personal Contact:_____ Phone:_____

Incident / Injury Data:

Date:___/___/____ Time:___:___ am ☐ pm ☐ Date of Report: ___/___/____
Description of Illness / Injury: Auto- Font 225 characters max

Family / Personal Contact Notified: Yes ☐ No ☐ Time:___:___ am ☐ pm ☐

Care Provided:

Did injured party refuse medical care? Yes☐ No☐ Was first aid provided? Yes☐ No☐
Person who provided care:_____ Phone: _____
Describe care provided: Auto – Font 225 characters max

Was E-911 called? Yes ☐ No ☐	Time: ___:___ AM☐ PM☐	By Whom?_____

Was injured party transported to a medical facility? Yes ☐ No ☐ If yes, by whom?_____	Name of Facility:_____ Address: _____

If no, did injured party return to activity? Yes ☐ No☐

If injured party is a minor, was his/her Parent / Guardian notified? Yes ☐ No ☐ Parent / Guardian Present ☐

_____
Injured / Parent / Guardian Signature Date: ____/____/_____

Witnesses:

1.Name:_____ Phone: _____
Address: _____ City: _____ State: _____ Zip:_____
2.Name:_____ Phone: _____
Address: _____ City: _____ State: _____ Zip:_____

Please attach any additional pictures, diagrams or statements.
Submit Report to the Office of Risk & Safety.