# Incident Report

## I. To be completed by Supervisor

<table>
<thead>
<tr>
<th>Name of Person Involved</th>
<th>Position</th>
<th>Department</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Age | Gender | ID/#/Patient # | Date of Incident | Time | Location |
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

### Status

- [ ] Staff
- [ ] Faculty/Medical Staff
- [ ] Resident Staff
- [ ] Student
- [ ] Casual Worker
- [ ] Visitor
- [ ] Inpatient
- [ ] Outpatient/ED Patient
- [ ] Other (Specify)

### Category of Incident

<table>
<thead>
<tr>
<th>Chemical/Radioactive Exposure</th>
<th>Fire</th>
<th>Breach of Safety</th>
<th>Treatment Problem/Delay/Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological Exposure</td>
<td>Flood</td>
<td>Breach of Security</td>
<td>Patient Fall</td>
</tr>
<tr>
<td>Laceration</td>
<td>Spill</td>
<td>Breach of Policies</td>
<td>Documentation Error</td>
</tr>
<tr>
<td>Back Injury</td>
<td>Property Damage</td>
<td>Breach in Scope of Practice</td>
<td>Misidentification</td>
</tr>
<tr>
<td>Slip/Trip/Fall</td>
<td>Equipment Failure</td>
<td>Breach of Confidentiality</td>
<td>Faulty Equipment/Product</td>
</tr>
<tr>
<td>Other Bodily Injury</td>
<td>Burn</td>
<td>Physical/Verbal Abuse</td>
<td>Other (Specify):</td>
</tr>
</tbody>
</table>

### Complete description of the incident and actions taken*

- (any objects, tools, chemicals, potential source of infection involved, etc.)

### Corrective measures to prevent similar incidents*

- [ ] Device With Safety Feature
- [ ] No
- [ ] Yes

## II. In Case of INJURY to be completed by Physician

### Nature of injury and body part(s) affected:

- [ ] None (No injury)
- [ ] Minor (Cleaning of wound or topical medication)
- [ ] Moderate (Suturing or splinting)
- [ ] Major (Surgery, neurological or internal injury)
- [ ] Catastrophic (Disability or death)

### Extent of Injury

<table>
<thead>
<tr>
<th>Medical Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the individual involved suffering from pre-existing disease or disability before the incident?</td>
</tr>
<tr>
<td>[ ] No</td>
</tr>
<tr>
<td>Diagnostic Procedure:</td>
</tr>
<tr>
<td>No Treatment</td>
</tr>
</tbody>
</table>

### Will the incident result in a permanent defect or disability?

- [ ] No
- [ ] Yes

### Was a sick leave given to the injured?

- [ ] No
- [ ] Yes \( \ldots \) days

### Additional comments by Physician*

- [ ] Physician Name: ......................................
- [ ] Physician Signature: ......................................
- [ ] Status: ......................................
- [ ] Date: ......................................

### I authorize the physician to release this report or any part of its content for administrative purposes

- [ ] Signature of Injured: ......................................

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*Use back of form or additional sheet if more space is needed

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*Complete description of the incident and actions taken* may include details such as the type of device involved, e.g., a Suture Needle, IV Catheter, Blade, or other devices. Corrective measures to prevent similar incidents could involve identifying the type of device used (Device With Safety Feature) and specifying whether it was Yes or No.

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*Additional comments by Physician* provide space for any further notes or observations that are relevant to the incident.