SAMPLE INCIDENT REPORT FORM (1)

Reporting Agency:	**Date & Time of Incident:**
Location of Incident:	**Name of Client:**
Person, Title, and Contact Information Reporting:	**Care Consultant:**

Incident Type:

☐ Injury- Client ☐ Property Loss ☐ HIPAA Violation / Privacy Breach

☐ Injury-Provider Staff ☐ Property Damage ☐ Other-*briefly state incident type*:

☐ Injury-Fall- Client ☐ Property Theft ☐ Other Health/Wellness

☐ Health/Medical Event ☐ Fiscal Incident (scams, credit card loss)

Any other witnesses to the incident: ☐ Yes (list names, titles, & contact information) ☐ No

Was medical treatment provided: ☐ Yes ☐No ☐ Refused

If yes, what treatment and by which agency:

Was EMS called: ☐ Yes ☐No ☐Unknown at time of report

If yes, was person transported: ☐ Yes ☐ No ☐ Unknown at time of report

If transported, where to:

Required Notification(s): *Consider: law enforcement, SourcePoint staff; HHS (HIPAA); other impacted parties*

Notification to outside organization/agency: ☐ No ☐ Yes (complete below)

Organization/Agency Contacted:

Date of Contact: Name of person contacted & contact information:

Include summary of contact on back

If property damage/loss/theft, name of owner/impacted party: Contact information:

What was damaged/lost/stolen:

Signature of person completing report	**Date:**

Description of Incident

Explain what happened, factors leading to event, what the injury/health event was, witnesses to the incident, was there property damage as well, etc. Attach additional sheets if necessary.

SAMPLE INCIDENT REPORT FORM (2)

For Internal Use This form must be completed within 24 hours of the Supervisor learning of the incident

☐ Injury: ☐ First Aid ☐ Medical Aid		☐ No Injury	☐ Hazardous Situation
THIS SECTION TO BE COMPLETED BY THE EMPLOYEE			
Who was hurt? ☐ Employee ☐ Visitor ☐ Contractor ☐ Other	Last name:	First Name:	Phone or Extension:
	Job Title:	Department:	Supervisor:
	Date & Time of Incident:	Date Reported:	Type of Incident: ☐ Slip*, trip or fall ☐ Struck by / against object ☐ Over exertion ☐ Repetitive strain ☐ Electrical contact ☐ Exposure to hazardous material ☐ Other (describe)
Description of Incident:			
*If this was a SLIP, describe footwear:			
Witnesses to the incident: (names and phone numbers)			
What was the injury (indicate what part of the body):			
Did you see a medical professional? ☐ Yes ☐ No If YES, please provide name, address and phone number:		Treatment of Injury: ☐ First Aid ☐ Walk-in Clinic ☐ Family Doctor ☐ Emergency Room ☐ Other (describe) ______________________	

THIS SECTION TO BE COMPLETED BY THE SUPERVISOR			
Contributing Factors: What conditions contributed to the incident?			
☐ Unsafe equipment ☐ Insufficient training ☐ Failure to use PPE	☐ Inadequate illumination ☐ Improper position/posture ☐ Operating without authority	☐ Not or improperly guarded ☐ Insufficient care ☐ Failure to lockout	☐ Hazardous environment ☐ Infraction or unsafe practice ☐ Other (Explain)
Explanation of contributing factors:			
Details of property damage (if any):			
To your knowledge, has the employee had a previous similar injury or has this similar hazard been reported before? ☐ Yes ☐ No ☐ N/A			
Corrective Measures: Actions taken to prevent a reoccurrence (more than one item may apply):			
☐ Request job safety analysis ☐ Improve work procedure ☐ Repair or replace equipment	☐ On-the-job training ☐ Check with manufacturer ☐ Install safety guard/device	☐ Perform housekeeping ☐ Re-training of person(s) ☐ Reassignment of person	☐ Review PPE ☐ Constructive Discipline ☐ Other (Explain)
Explanation of corrective measures:			

Signature of Employee Reporting Incident:	**Date:**	**Signature of Supervisor:**	**Date:**