GODSHALL

Incident Report

Name of Facility: _____
Location where incident occurred (Number, Street, City, State): _____
Did the accident occur on employer's premises? ☐ Yes ☐ No
Location where the incident occurred (patient room, department, etc.): _____

Name of Employee (first, middle initial and last name): _____
Address (Number, Street, City/State/Zip): _____
Telephone:_____ Cell Phone: _____
Age:_____ Sex:_____ Marital Status: _____

Number of days worked per week _____
Time began work on injury day: Time:_____am ____pm ___
Date of incident:_____ Time:_____am pm Day of the week: _____
Dated reported:_____ Time:_____am pm Name of Supervisor: _____
If any delay in reporting, explain why: _____
Hours missed on the day of incident: _____

Describe the incident fully, including how it occurred, what you were doing, how it was being done, and any objects, equipment, tools, or medication that were involved: _____

Were you doing something other than your required duties at the time?	☐ Yes	☐ No
Were safety rules violated?	☐ Yes	☐ No
Was the incident caused by a person (other than yourself)?	☐ Yes	☐ No
Was the incident caused by failure of machinery or products?	☐ Yes	☐ No
Was anyone injured as a result?	☐ Yes	☐ No

If you answered Yes to any of the questions above, please explain:

Names and phone numbers of witnesses: _____

Comments and description:

If a patient was injured, describe the injury in detail, including part of body and extent of injuries. (If you were injured, complete the Accident/Incident Report.): _

_____
_____
_____
_____

What is the probable outcome: _

_____
_____
_____
_____
_____

For Office use only:

Patient Safety Event	❒ Yes	❒ No	If yes, select type below.
No Harm Event	❒		
Close Call	❒		
Hazardous Conditions	❒		
Adverse Event	❒	***Sentinel Event** ❒ Yes	❒ No

Corrective Action: Report Completed by:

Employee's Signature: Date: