**PATIENT INCIDENT REPORT FORM**

Use this form to report accidents, injuries, medical situations, criminal activities, traffic incidents, or student behavior incidents. If possible, a report should be completed within 24 hours of the event.

Date of Report: [DATE]

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| 1. **PERSON INVOLVED** |

Full Name: [NAME] Address: [ADDRESS]

Identification:  Driver’s License No. [#]  Passport No. [#]  Other: [OTHER]

Phone: [PHONE NUMBER] E-Mail: [E-MAIL ADDRESS]

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| 1. **THE INCIDENT** |

Date of Incident: [DATE] Time: [TIME]  AM  PM

Location: [LOCATION]

Describe the Incident: [DESCRIBE THE INCIDENT]

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| 1. **INJURIES** |

Was anyone injured?  Yes  No

If yes, describe the injuries: [DESCRIPTION OF INJURIES]

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| 1. **WITNESSES** |

Were there witnesses to the incident?  Yes  No

If yes, enter the witnesses’ names and contact info: [NAMES OF WITNESSES]

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| 1. **POLICE / MEDICAL SERVICES** |

Police Notified?  Yes  No If yes, was a report filed?  Yes  No

Was medical treatment provided?  Yes  No  Refused

If yes, where was medical treatment provided?  On site  Hospital  Other: [OTHER]

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| 1. **PERSON FILING REPORT** |

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **OFFICE USE ONLY** |

Report received by: [NAME] Date: [DATE]

Follow-up action taken:

Action Taken: DESCRIBE]