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: _____, 20____

PERSON INVOLVED

Full Name: _____ Address: _____

Identification: ☐ Driver's License No. _____ ☐ Passport No. _____
☐ Other: _____

Phone: (____) ____-_____ E-Mail: _____

THE INCIDENT

Date of Incident: _____, 20____ Time: ____:_____ ☐ AM ☐ PM

Location: _____

Describe the Incident: _____
_____
_____

INJURIES

Was anyone injured? ☐ Yes ☐ No

If yes, describe the injuries: _____
_____
_____

WITNESSES

Were there witnesses to the incident? ☐ Yes ☐ No

If yes, enter the witnesses' names and contact info: _____
_____
_____

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: _____

PERSON FILING REPORT

Signature: _____ Date: _____

Print Name: _____

OFFICE USE ONLY

Report received by: _____ Date: _____, 20____

Follow-up action taken: _____
_____
_____