INCIDENT/COMPLAINT REPORT

EMPLOYEE: Return this COMPLETED FORM to your SUPERVISOR as soon as possible.

Name of Person Involved:

_____

Address: _____ City:

_____

Phone Number: _____ Age: _____ DOB: _____ Sex: M ____ F _____

SS#: _____ Date of Incident: _____ Time: _____ am/pm

Exact Location of Incident:

_____

Check Type of Accident: Check:

- Clerical/Data Entry _____ Patient
- Communications _____ Employee
- Testing Process _____ Visitor
- Result reporting _____ Volunteer
- Safety _____ Other
- Medical Device Failure
- Policy/Procedural Violations
- Adverse Drug Reaction
- Vehicle Accident
- Needlestick
- Exposure to Hazardous Substance
- Medication Error (Wrong: Route, Dosage, Medication, Schedule)

EMPLOYEE: Involved _____ yes _____ no

Were they doing their regular job duties: _____ yes _____ no Observed by employee yes

Hire Date: _____ Marital Status: _____ Situation observed