INCIDENT REPORT FORM

This form can be used to meet the reporting requirements for accident, injury, illness, hospitalization, emergency room treatment, death or fire.

Name of Facility		Telephone Number
Facility Address		
Name of Person	Sex ☐ M ☐ F	Birth Date
Person's Address		Telephone Number

DESCRIPTION OF INCIDENT

Date	Time ☐ AM ☐ PM	Location
Equipment/Product/Person Involved	Type of Injury/Incident	Part of Body Injured
Cause of Injury		

ACTION TAKEN

First-Aid Given By Facility		
Name of Local Authority Notified of Incident		Telephone Number
Address		
Treatment Provided	Telephone Number	Address
Nature of Treatment		
Required Follow-Up		

Signature of Facility Person Completing the Form	Title	Date
☐ I request ☐ Do not request additional Investigation of this incident.		
Signature of Person or Personal Representative		Date