ACCIDENT/INCIDENT REPORT

Name_________________________________________ Date of Report_________________

Date of Accident/Incident______________ Time of Accident/Incident______________

Others Involved___________________________________________________________

Was this an:  ___Accident  ___Injury  ___Illness   ___Behavioral Incident
          ___ Community Incident   ___Medication Related   ___Other

Antecedent:  What caused the accident/incident or occurred just prior?
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Consequence: Action taken. What did you do to resolve the situation? Describe any first aid, by who, transport to the hospital; by whom, transport to the physician; time, etc.
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________________________________________________________________________

Who was notified? (supervisor, administrative personnel, guardian, physician, etc.)
Notification must be within 24 hours of the Accident/Incident

Name:____________________________________________ Date:_________________ Time_________________
Name:____________________________________________ Date:_________________ Time_________________
Name:____________________________________________ Date:_________________ Time_________________

Signature of person completing form      Date

Signature of Supervisor        Date