



## Facility Incident Report

Facility where incident occurred \_\_\_\_\_ Date \_\_\_\_\_

Injured person \_\_\_\_\_

Address \_\_\_\_\_  
*Street City State Zip*

Emergency Contact (If Available)

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

<b>Incident date</b> ____/____/____ Time ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm	<b>Gender</b> Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>Age</b> _____	<b>Status</b> Guest <input type="checkbox"/> Client <input type="checkbox"/> Other <input type="checkbox"/> _____
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### General Information

Describe exactly what happened. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical Information

Describe the injured party's condition and any first aid. Was first aid given? \_\_\_\_\_ Blood-borne exposures? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Further medical attention? \_\_\_\_\_ If so, where and by whom: \_\_\_\_\_

Was parent / guardian / emergency contact notified? \_\_\_\_\_ If so, when? \_\_\_\_\_

**INJURED PERSON:**

**DATE:**

Who was called and what was the outcome?

\_\_\_\_\_

With whom did the injured party leave the site?

\_\_\_\_\_

**Witnesses (Indicate Staff [S], Client [C], Other (O) or Volunteer [V])**

S	C	O	V	Name	Address	City	State	Zip	Phone

**Incident Management**

Signature of injured person (18 and over) \_\_\_\_\_ Date \_\_\_\_\_

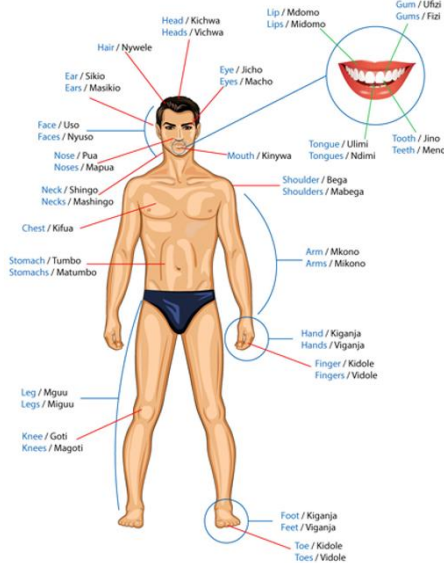
Employee Filing Report \_\_\_\_\_ Position \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Administrator Reviewing Report \_\_\_\_\_ Position \_\_\_\_\_ Date \_\_\_\_\_

**Body Part(s) Injured and Initial Treatment**

(Circle all areas where the injury occurred and treatment was rendered below)



**Initial Treatment Provided? If Yes, What?**

\_\_\_ None Given (Not Required)

\_\_\_ RICER

\_\_\_ Dressing/Bandages

\_\_\_ CPR / Defibrillator

\_\_\_ None Given - Referred Elsewhere

\_\_\_ Other Treatment

\_\_\_\_\_

**Who Provided Treatment?**

\_\_\_ Office Staff

\_\_\_ Psychotherapist/BHP

\_\_\_ Ambulatory Services

\_\_\_ Other Provider \_\_\_\_\_

**INJURED PERSON:**

**DATE:**

**Specific Location of Incident**

- Meeting Room
- Lobby / Halls / Stairs
- Elevators

- Restroom
- Parking Lot / Garage
- Outdoor Patio Seating Area / Building Grounds

Other \_\_\_\_\_

**Incident Location Photos**

A minimum of five (5) photos are required to be attached to this incident report. Where were photos taken to back up the incident report (DO NOT take pictures of client injuries unless specifically asked to do so!)?

- Meeting Room
- Lobby / Halls / Stairs
- Elevators

- Restroom
- Parking Lot / Garage
- Outdoor Patio Seating Area / Building Grounds

Other \_\_\_\_\_

**Follow-up required by Supervisor or Executive Leadership within 48 hours of the incident**

Follow up date \_\_\_\_\_ And by whom? \_\_\_\_\_

Detail status. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Notes & Internal Corrective Actions to Prevent Incident Happening Again:**

Describe additional information here as well as preventative practices deployed to limit similar incidents from happening in future. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Incident Submission Information**

Date Filed

Facility Location