

INCIDENT/COMPLAINT REPORT

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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:

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

Check:

- _____ Patient
- _____ Employee
- _____ Visitor
- _____ Volunteer
- _____ Other

If Required, Financial Loss Report Completed

EMPLOYEE: Involved _____ yes _____ no

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

Hire Date: _____ Marital Status: _____ Situation observed only by employee yes

Employee Classification: _____

Protective Equipment being used: _____ yes _____ no

If not used, Why: _____

Description of Incident/Complaint (Who, What, Where, How, Why, Include sequence of events, personnel involved, body part injured, reason incident occurred) (If medication error include brand name, manufacturer, dosage) (Use additional form if necessary)

Actions Taken by Staff Members: _____

Witness Name: _____ Phone Number: _____

Address: _____

Witness Name: _____ Phone Number: _____

Address: _____

MEDICAL FOLLOW-UP: Was Medical Attention Sought: _____ yes _____ no

Treatment Refused: _____ yes _____ no First Treatment Date: _____

Treating Physician: _____ Phone Number: _____

Address: _____

First Day Off Work: _____ Return to Work Date: _____

Duties Restricted: _____ yes _____ no Explain: _____

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Incident Reported By: _____ Date: _____

Supervisor Notified: _____ yes _____ no Date: _____ Time: _____

Name of Supervisor: _____

Signature and Title of Person Preparing Report: _____ Date: _____

Supervisor Comments: _____

Supervisor Signature: _____ Date: _____

Corrective Action Taken/Follow-Up: (Things that have been or will be taken to prevent recurrence)

Director Comments: _____

Director Signature: _____ Date: _____

Nursing Administrator Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

Signature of Person making Complaint: _____ Date: _____

Worker Compensation first Report Sent: _____ yes _____ no Date: _____ OSHA 300 Log # : _____

_____ I understand the potential risks related to the exposure to the incident that occurred and agree to receive an examination and/or treatment for the exposure, as recommended by my physician. This includes serological testing for Hepatitis B and the HIV virus as indicated.

_____ I understand the potential risks related to the exposure incidents that occurred and DO NOT agree to have an examination or treatment for the exposure.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

I understand the information above will be used by my employer to help determine liability for injury. I acknowledge that the above statements are true and accurate representation of the requested information.

Employee Signature: _____ Date: _____

Job Title: _____

Testing for HBV: Baseline and 6 months*

Testing for HIV: Baseline, 6 weeks, 3 months, 6 months, and 1 year**

Current references may be found on the CDC website: www.cdc.gov "(Morbidity and Mortality Weekly Report [MMWR], June 29, 2001/Vol.50/No.RR-11 or latest version"; Morbidity and Mortality Weekly Report [MMWR], September 30, 2005/Vol.54/No. RR-9, update)