

**GREEN RIVER DISTRICT HEALTH DEPARTMENT
INCIDENT REPORT or ABNORMAL OCCURRENCE
(Please Print)**

Check Category of person involved:

- Employee: _____
 Nurse Office Environmental/Maintenance
 Patient/Client Visitor Other _____

Address: _____ **City:** _____ **Zip Code** _____

Phone Number: _____ **DOB:** _____ **Sex:** M ___ F ___ **SS#:** _____

Date of Incident: _____ **Time of Incident:** _____ **am/pm**

Location of Incident:

- Health Department
 Clinic Room _____
 Lobby
 Office _____
 Parking Lot
 Sidewalk
 School _____
 Patient Home: Address only _____
 Street/Road _____
 Site Visit: _____

County Reporting Incident:

- Daviess Hancock Henderson McLean Ohio
 Union Webster District Office Other _____

Type of Incident or abnormal occurrence:

- Animal/Human/Insect Bite
 Auto Accident
 Bloodborne Pathogen
 Building problem
 Clerical Error
 Environmental
 Fainting
 Fire/Explosion/Electric
 Infectious Disease Exposure Type: _____
 Injury
 Quality of care concern
 Shattered Tube
 Splash
 Theft/ Vandalism
 Trip/Fall
 Other _____
 Medication Error:
 Drug Allergy
 Wrong Dose
 Wrong Medication
 Wrong Patient
 Wrong Route
 Wrong Time
 Medication Storage
 Medical Illness
 Puncture
 Slips/Fall
 Suicide/Homicide
 Threats (Bomb, Phone)
 Violence (workplace, domestic)

Nature of Injury:

- Allergic Reaction
 Burn/Scald
 Cuts/ Scrapes/Bruises
 Rash
 Swelling/knots/bumps
 Bloodborne Pathogen Exposures
 Other: _____
 Back Injury
 Broken/Fractured/Dislocation bone
 Needle stick/puncture
 Sprain/Strain
 Contagious or Infectious Disease
 No Apparent Injury

Please describe incident/abnormal occurrence in detail (Who, What, Where, How, When, Include sequence of events, personnel involved, body part injured: left, right, lower back, etc.) (Use additional paper if needed.)

Employee doing their regular job duties: Yes__ No__ Protective equipment being used: Yes__ No__ NA __
If protective equipment not being used, why:

Witnesses: _____ Phone Number: _____

_____ I understand my employer may use the above information to help determine liability for injury. I acknowledge that the above statements are true and accurate representation of the requested information.

_____ I understand the potential risks related to an exposure by 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, Hepatitis C and the HIV virus as indicated by risk assessment.

_____ 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: _____ (Send to your supervisor)

Immediate Supervisor's Report: If report involves injury to employee, please send immediately to Human Resources.
Confirmation of above information, assessment of the incident, assessment of injury, etc:

Supervisor's Follow-up action: Write down action taken, note date and time. Attach any appropriate documentation.

Supervisor Signature/Date: _____ (Send to your director)

Program Director Signature/Date: _____ (Send to Human Resources)

Risk Assessment and Follow-up:

of attachments: _____

Signature and date: _____