

APPENDIX I: INCIDENT/OCCURRENCE REPORT

I. To be completed by Supervisor

Name of Person Involved	Position	Dept	Age	Gender
Date of Incident	Time	Location		

Occupation/status

<input type="checkbox"/> Staff	<input type="checkbox"/> Faculty	<input type="checkbox"/> House Staff	<input type="checkbox"/> Casual	<input type="checkbox"/> Student	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient & ER	<input type="checkbox"/> Visitor	<input type="checkbox"/> Other
ID#:								

Category of Incident

<input type="checkbox"/> Needle Pricks	<input type="checkbox"/> Physical Trauma	<input type="checkbox"/> Spills	<input type="checkbox"/> Fires	<input type="checkbox"/> Near miss	<input type="checkbox"/> Treatment problem/delay	<input type="checkbox"/> Breach of confidentiality	<input type="checkbox"/> Breach in scope of practice
<input type="checkbox"/> Back Injury	<input type="checkbox"/> Equipment	<input type="checkbox"/> Chemical/Biological/ Radioactive Exposure	<input type="checkbox"/> Floods	<input type="checkbox"/> Sentinel event	<input type="checkbox"/> Treatment error	<input type="checkbox"/> Breach of safety/Security	<input type="checkbox"/> Documentation error
<input type="checkbox"/> Bodily Injury	<input type="checkbox"/> Laceration	<input type="checkbox"/> Physical/verbal abuse	<input type="checkbox"/> Property damage/loss	<input type="checkbox"/> Fall	<input type="checkbox"/> Neglect	<input type="checkbox"/> Breach of policies	<input type="checkbox"/> Other (specify)

Complete description of incident and action(s) taken (Include any objects, tools, chemicals, potential source of infection involved, etc.) *

Corrective measures to prevent similar occurrences *

In Case of Personal Injury

Cause of Injury		Agent of Injury	
<input type="checkbox"/> Caught Between	<input type="checkbox"/> Inhalation/ Ingestion/ Absorption	<input type="checkbox"/> Boilers/ incinerator/ steam pipes	<input type="checkbox"/> Needles
<input type="checkbox"/> Chemical/Biological Splash	<input type="checkbox"/> Struck Against	<input type="checkbox"/> Chemicals	<input type="checkbox"/> Radiation
<input type="checkbox"/> Contact With Electric Current	<input type="checkbox"/> Struck By	<input type="checkbox"/> Electric apparatus	<input type="checkbox"/> Stairs
<input type="checkbox"/> Extreme Temperature	<input type="checkbox"/> Slips/trips/falls	<input type="checkbox"/> Hand tool	<input type="checkbox"/> Surfaces
<input type="checkbox"/> Improper Handling	<input type="checkbox"/> Sharp Object	<input type="checkbox"/> Ladders	<input type="checkbox"/> Vehicle
<input type="checkbox"/> Equipment Failure	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Machine	<input type="checkbox"/> Other (specify)

Completed by _____ Signature	Statement of involved person or person completing the report
Witnessed By _____ Signature	
Date _____	Name & Signature of Dept Head/Supervisor

II. In case of INJURY to be completed by Attending Physician

Nature of injury and body part affected:

Extent of Injury	Medical Intervention
<input type="checkbox"/> No injury No effect	Was the individual involved suffering from pre-existing disease or disability before the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Minor e.g. Scrape/bruise	<input type="checkbox"/> Diagnostic procedure:
<input type="checkbox"/> Moderate e.g. x-ray/laceration	<input type="checkbox"/> Treatment (Medical/Surgical):
<input type="checkbox"/> Major e.g. Fracture/Head injury	<input type="checkbox"/> No treatment
<input type="checkbox"/> Catastrophic e.g. Disability / death	Will the incident result in a permanent defect or disability? <input type="checkbox"/> Yes <input type="checkbox"/> No

No Sick Leave Sick leave Days

I authorize the physician to release this report or any part of its content for administrative purposes.

لقد تم شرح محتويات هذا التقرير و إني أخول الطبيب إبراز هذا التقرير أو أي جزء منه إذا اقتضت الحاجات الإدارية

Signature of the Injured

* Use back or additional sheet if needed

Distribution: If patient-related, send to hospital risk manager; if non-patient-related, send to EHSRM.