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Incident Report Form

Name: _____

Client: _____ Unit: _____

Date of Incident: _____ Time of Incident: _____

Were there witnesses to the Incident? Yes No If so, who? _____

Description of Incident: (Categorize incident as indicated below if hospital policy limits details)

- Category 1 (Call lights not answered, didn't follow Dr's Orders)
- Category 2 (Errors WITHOUT negative outcome, i.e., delay in treatment for patient services, med errors)
- Category 3 (Any errors with negative outcome causing harm or death)

Was Med Plus Staffing notified of the incident within a 24 hour period of occurrence? Yes No

Who at Med Plus Staffing was notified? _____

Date of Notification _____ Time of Notification: _____

Means of notification: Phone Email Fax

Requested resolution to incident:

Med Plus Staffing Follow up/ Resolution:

Med Plus Staffing Representative

Date