



**INCIDENT REPORT FORM:**

Name: \_\_\_\_\_

Client: \_\_\_\_\_ Unit: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_

Were there witnesses to the Incident? Yes or 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, ie delay in treatment for patient services, med error)

Category 3: (Any errors with negative outcomes causing harm or death)

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

Who at Med Plus Staffing was notified? \_\_\_\_\_

Date of Notification: \_\_\_\_\_ Time of Notification: \_\_\_\_\_

Means of Notification: Phone Email Fax Text

Requested resolution to incident:

Med Plus Staffing Follow up/Resolution:

\_\_\_\_\_

Employee Signature:

\_\_\_\_\_

Date Form Submitted:

