RawlinsCounty Dental Clinic Incident Report

INSTRUCTIONS Employees shall report all work-related accidents, injuries, illnesses - orunplanned events which could have resulted in an injury or illness - using this form. Once completed, this form shall be given to a manager for next steps.

I AM REPORTING A WORK RELATED:	✔	INJURY		MEDICAL EMERGENCY		OTHER:

YOUR NAME	SUPERVISOR NAME	DATE OF REPORT

JOB TITLE	Has your supervisor been made aware of this incident?

LOCATION OF INCIDENT	DATE OF INCIDENT	TIME

WITNESSES/OTHER PRESENT *if any*

INCIDENT DESCRIPTION Describe tasks being performed and sequence of events. *Attach additional pages as necessary.*

Was there anything that could have avoided the incident?

Was a physical injury sustained to any staff/patients/visitors?

Was medical treatment necessary?				IF YES, NAME OF HOSPITAL / PHYSICIAN:
	YES		NO	
DATE OF VISIT		TIME OF VISIT		HOSPITAL / PHYSICIAN PHONE

Has this part of your body been injured before?		YES		NO	If YES, when?	

Do you have other employment?		YES	✔	NO	Company Name	

EMPLOYEE SIGNATURE	**DATE**	**SUPERVISOR SIGNATURE**	**DATE**