



INSTRUCTIONS: This form is to be completed for any injury, incident, or unusual occurrence involving a student, employee, or visitor on the College premises or on assigned clinical rotation site.

Time and Place of Occurrence	Place: _____ Department: _____ _____ 20_____ Time: _____ m
Name of Student, Employee, Visitor	Full Name: _____ Address: _____ Date of Birth: _____ If employee, Date of Hire: _____
Patient Name (if applicable)	Full Name: _____ Rm. #: _____ Attending Physician: _____
Witnesses	IMPORTANT: Give full name and address of every individual who witnessed incident. Names _____ Addresses _____ _____ _____
Description of Incident/ Injury	Describe incident clearly and concisely mentioning contributing factors. Include the following four elements: what the person was doing just before incident, exactly what happened, the nature of the injury or illness and what object directly harmed the victim. For incident involving student, instructor should also describe incident as observed or as related to instructor. (Use back of page if more space is needed.) _____ _____ _____ _____
First Aid and/or Medical Treatment	Was first aid provided? <input type="checkbox"/> Yes <input type="checkbox"/> No Was student/employee/visitor treated in Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No Was student/employee/visitor treated by physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, physician name & full address: _____ _____ _____ Was lab work required? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of medical examination: _____ Was student/employee/visitor hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No Follow-up treatment required? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____ _____ _____

Signature of Preparer: _____ Date: _____
Signature of Instructor: _____ Date: _____