His Vision Healthcare Services, LLC

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Incident Report Form

_____ _____ ☐ AM • ☐ PM
Date of Incident Time of Incident

_____ _____
Client Name Date of Birth

Method of Report: ☐ Telephone • ☐ Written
Person Reporting Incident ☐ Client • ☐ Family Member ☐ Doctor's Office ☐ Friend • ☐ Other: _____

_____ _____
Complainant Full Name Primary Phone #

_____
HVHS Employee Receiving Incident Report

Description of Incident: _____
_____
_____
_____

_____ _____ _____ ☐ AM • ☐ PM
Name of Supervisor Informed Date Time
Nature of Incident: **Emergency** ☐ Yes • ☐ No

If yes, what type of resolution/action was taken and by who: _____
_____
_____

Fully describe **COMPLAINT** (use extra sheets if necessary): _____
_____
_____

Was situation resolved? ☐ Yes • ☐ No
If yes, how was it resolved: _____
_____
_____

If no, what further action needs to be taken: _____
_____
_____

_____ _____
HVHS Staff Member Signature Date