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Incident Reporting Form

Use this form to report any workplace accident, injury, incident, close call or illness.
Return completed form to the Operations Supervisor, or Management.

INCIDENT (Check all that apply or indicate other):

☐ Abuse	☐ Fire	☐ Property-damage
☐ Aggression/Violence	☐ Fire Alarm	☐ Property-building problem
☐ Baker Act	☐ Illness	☐ Property-prowlers at premises (loitering)
☐ Biohazard	☐ Infection outbreak and control	☐ Rules violation
☐ Bomb threat	☐ Injury-requiring medical attention	☐ Seclusion or restraint
☐ Community concern	☐ Injury-not requiring medical attention	☐ Sexual harassment
☐ Confidentiality violation	☐ Left property-unauthorized	☐ Suicide attempt
☐ Death-consumer (sentinel event)	☐ Media-exposure	☐ Suicide ideation
☐ Death-other	☐ Medical condition (known)	☐ Theft/robbery
☐ Drug/Alcohol-use	☐ Medication variance	☐ Use of seclusion or restraint
☐ Drug/Alcohol-possible overdose	☐ Missing person	☐ Vehicle Accident
☐ Elopement-missing	☐ Neglect	☐ Other_____
☐ Elopement-returned	☐ Poor quality of care concern	
☐ Fall or Slip	☐ Possession-drugs/contraband	

LOCATION OF INCIDENT (Check all that apply or indicate other):

☐ Automobile-Gulf-Coast	☐ Front/Back Porch	☐ Nursing Home
☐ Automobile- Other	☐ Hallway	☐ Nursing Station
☐ Bathroom	☐ Hospital	☐ Office
☐ Consumer's Home	☐ Kitchen	☐ Parking Lot
☐ Consumer's Room	☐ Main Social Area	☐ Private Business/Store
☐ Dining Room	☐ Non-Gulf Coast Facility	☐ School
☐ Foster Home	☐ Not Reported/Unknown	☐ Other_____

14. WITNESSES:

_____

_____

_____

_____

_____

Person Completing Report:_____ Date:_____
Person(s) Involved:_____

Event Details

Date of Event:_____ Location of Event:_____

Time of Event:_____ Witnesses:_____

Description of Events (Describe tasks being performed and sequence of events):

_____

_____

_____

_____

_____

*If more space is required please use the back of this sheet

Was event / injury caused by an unsafe act (activity or movement) or an unsafe condition (machinery or weather)? Please explain:

_____

_____

TO BE COMPLETED ONLY IF LOST TIME/INJURY OR FIRST AID WAS REQUIRED	
Type of injury sustained:	
Cause of lost time/ injury or first aid:	
Was medical treatment necessary?	Yes_____ No_____ If yes, name of hospital or physician:

Staff Sponsor(s)

Signature of Staff Sponsor Program Name and Staff Title Date:

_____

Signature of Staff Sponsor Program Name and Staff Title Date:

Aime Kalangwa
Chairperson, Executive Director of the Company and Founder
Signature of Staff Sponsor Date: