Office Use

Type of Incident: ______________________________

Injury: Y/N **Safety Protocol followed: Y/N**

Education Provided:Y/N

HR file: Y/N

Patient Incident/Accident Report

Facility: ______________________

Employee Name: ______________________ **Full Time/PRN:** ________

Job Title: ______________ **Length of Time in this Position:** ________

Supervisor Name: ______________________

Patient Information:	Patient Name:	
Male/Female:	Patient Age:	Patient Weight:
Patient Diagnosis:		

Today's Date:			
Date of Incident:			
Time of Incident:		am	pm

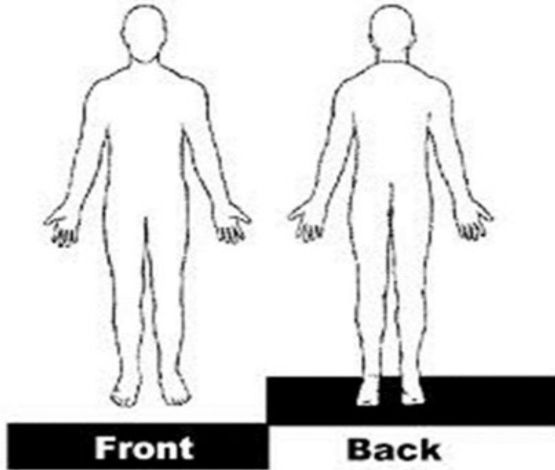
Employee Statement of Incident:

Include ( )What occurred ( )Why incident occurred ( ) Equipment used ( ) Location of incident

Was the patient injured?	**Yes/No**	**Gait Belt in use?**	**Yes/No**

Signature of Employee Date:

Location of Injury: (To be completed by Employee)



Type of Injury:

1. Lacertion	
2. Hematoma	
3. Abrasion	
4. Burn	
5. Swelling	
6. Skin Tear	
7. None Apparent	

8. Other (Spefify below):

____

____

To Be Completed by Supervisor:

Supervisor Statement:

____

Signature of Supervisor Date:

Has the employee been involved in any other patient incidents in the last 12 months?

If so, how many including this incident? ________________________

Was therapist following Physician approved POC, providing appropriate level of supervision & observing precautions?

Yes/No *Details if needed:*

Was Employee Injured? **Yes/No** *If yes, AD and HR must be notified immediately*

Was onsite medical care adminstered to the patient? **Yes/No**

If Yes, type of care provided, by whom, & time provided:

Did patient require additional medical care? **Yes/No**

If yes, provide details and attach any records or x-rays obtained :

Was Area Director Notified? Date:_____________ How? (Circle) Email, Phone, Fax

Was Administration at Facility Notified? **Yes/No**

Was Facility Incident/Accident Report Completed? **Yes/No**

Was the Facility provided a copy of TR incident report? **Yes/No**

To Be Completed by Witness:

Statement of Witness to Patient Incident:

Describe the incident? What did you see, hear, do, etc?

Witness Signature **Date:**

Corporate Office:

Area Director Signature Date:

AD Investigation Required? **Yes/No**
If Yes, Report Completed? **Yes/No**

Clinical Specialist Signature Date:

Clinical Investigation Required? **Yes/No**
If Yes, Report Completed? **Yes/No**

Director of Compliance & Clinical Services Signature Date:

Did incident result in disciplinary action for Employee? **Yes/No**
Disciplinary Action Taken:
Clinical Investigation Required? **Yes/No**
If Yes, Report Completed? **Yes/No**

Follow Up Required? **Yes/No**

Investigation Completed? **Yes/No**

Details for Follow Up,

Liability Insurance Company Notified? **Yes/No**

Updated 9.7.22