



REPORTABLE EVENT FORM

This report and the information contained therein is a privileged communication to the Office of Corporate Compliance and is protected under the Attorney/Client privilege. The Office of Corporate Compliance has authorized the Risk Management Specialist to collect and investigate incidents reported therein. (If you have any questions, call 327-6444).

Please complete this report (in its entirety) in the event of an accident, discovery of a hazardous condition, or any occurrence which is not consistent with routine operation of the institution or routine care of a patient. Submit all forms to Risk Management, Lyttle Hall, 3 rd Floor, Room 317, in the Office of Corporate Compliance.		1 NAME _____ ADDRESS _____ _____ PHONE (H) _____ (W) _____ AGE _____ SEX _____					
2	EXACT LOCATION OF INCIDENT	BLDG/DEPT	FLOOR	ROOM NO.	DATE	TIME	AM PM
	DISCOVERED BY		TITLE				
3	INCIDENT <input type="checkbox"/> 1E Slip/Fall <input type="checkbox"/> 2E Medication <input type="checkbox"/> 3E Injury <input type="checkbox"/> 4E Equipment <input type="checkbox"/> 5E Procedures <input type="checkbox"/> 6E Elopement/AMA <input type="checkbox"/> 7E Sharp Instr. Injury <input type="checkbox"/> 8E Theft/Break-In <input type="checkbox"/> 9E Auto Accident <input type="checkbox"/> Fire/Flood <input type="checkbox"/> Evacuation <input type="checkbox"/> Other						
		CONCISE DESCRIPTION OF OCCURRENCE (STATE SIGNIFICANT FACTS IN CHRONOLOGICAL ORDER, I.E., INCLUDE SPECIFIC ENTRANCE/EXIT OR CONDITION SURROUNDING INCIDENT) _____ _____ _____ _____ _____ _____ _____ _____					
4	WITNESSES	NAME		HOME ADDRESS		TELEPHONE NO.	
		NAME		HOME ADDRESS		TELEPHONE NO.	
5	BACKGROUND Inpatient Outpatient	PATIENT'S DIAGNOSIS					ADMISSION DATE
		SURGICAL PROCEDURE/OUTPATIENT TREATMENT					
		Medication Within Past 8 Hours	Yes No	NAME OF MEDICATION	SEDATIVE LAXATIVE	DURETIC OTHER	
6	Visitor Employee Student Other	REASON FOR BEING AT FACILITY					
		Department	Title			On Duty YES NO	
7	Treatment	Was There an Injury? Yes No		Patient/Family Aware of Incident? Yes No		Was Examination or Treatment Refused? Yes No	
		Attending Physician Notified? Yes No		Injured Person's Signature, If Yes		Time _____ AM PM	
		X-Ray Ordered Yes No Results (If Known) _____ Diagnosis and Recommendation _____ _____ _____ SIGNATURE _____ MD					
8a	REPORTING	EMPLOYEE MUST REPORT INCIDENT TO SUPERVISOR. STUDENT MUST REPORT INCIDENT TO THE DEAN OF STUDENT AFFAIRS. VISITOR MUST CALL THE DEPARTMENT OF PUBLIC SAFETY AT 327-6666.					
8b	FOLLOW-UP	INVESTIGATION REPORT WILL BE COMPLETED BY RISK MANAGEMENT.					
9a	TYPE OR PRINT NAME OF PERSON COMPLETING THIS REPORT						
9b	SIGNATURE OF PERSON COMPLETING THIS REPORT			TITLE		DATE	

This report is for data analysis and loss control purposes only. It is not to be construed as notification to the insurance company of possible claim.