Total Medical Personnel Staffing

FACILITY ACCIDENT/INCIDENT REPORT

Name of Facility: _____

Date of incident: _____ Time: _____ AM/PM

Name of injured Total Medical Employee_____

Address: _____

Phone Number(s):_____

Date of birth: _____ Male _____ Female _____

Who was injured person? (circle one) Patient Agency Employee

Type of injury/incident_____

Details of incident: _____

_____

_____

_____

_____

_____

Injury requires physician/hospital visit? Yes ___ No _____

Signature of Facility Supervisor _____

Date

Signature of injured party _____

Date

*No medical attention was desired and/or required.

_____

Signature of injured party Date