Broad Top Area Medical Center, Inc.
Incident Report Form

Facility/Clinic: _____ Date of Incident: _____Time of Incident: _____ am/pm

Name of Person(s) affected by incident: _____

Location in Facility/Clinic where incident occurred: _____

Name of Person(s) involved/witnessing Incident: _____

_____

Name, Address, Telephone Number of (non-Broad Top Area Medical Center) Witness(es)*

_____

Provider Name: _____ Date Nursing, QM, and/or HR Notified: _____

Details of Incident. Please write legibly and be very specific. (Attach additional sheets as needed.)

_____

_____

_____

_____

_____

_____

_____

Did this incident result in an injury? (Circle one) Yes / No Type of Injury: _____ Location: _____

Action Taken: _____

_____

_____

_____

Is there any further follow up required? _____

_____

How did patient, employee, family, and/or facility react to this incident?

_____

_____

Incident Reported To: _____

I hereby attest that the facts stated herein are true to the best of my knowledge.

_____ _____

Completed by (Please Print) Signature Date

_____ _____

BTAMC Provider (Please Print) Signature Date

BTAMC Inc.