MEDICAL INCIDENT REPORT

Location of Incident: _____ Time of Incident: _____

Reporter Information:

Full Name: _____

Position/Title: _____

Department: _____

Contact Information (Phone/Email): _____

Patient Information:

Full Name: _____

Date of Birth: _____

Patient ID / Medical Record No.: _____

Gender: _____

Contact Information (if different): _____

Incident Details:

Type of Incident: _____

Location within Facility: _____

Description of Incident:

Injuries Sustained:

Witnesses (if any):

Immediate Actions Taken:

Legal Compliance and Waiver

This Medical Incident Report is a true and accurate account of the incident to the best knowledge of the reporting personnel. The information herein is confidential and subject to all applicable United States federal and state privacy laws including HIPAA. Unauthorized disclosure or use of this report or its contents is strictly prohibited.

Governing Law and Jurisdiction

This report and any related actions or disputes arising herefrom shall be governed by and construed in accordance with the laws of the United States and the relevant state jurisdiction where the incident occurred. Any legal proceedings must be brought exclusively in the appropriate state or federal courts of that jurisdiction.

Acknowledgment

By signing below, the reporting personnel and reviewer attest to the accuracy and completeness of this report and acknowledge understanding of the legal implications of submitting false or misleading information.

Reporting Personnel Signature	**Supervisor Signature**
Signature: _____	Signature: _____