

# 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: \_\_\_\_\_

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