ALLIED EMS

INTERDEPARTMENT OCCURANCE / INCIDENT REPORT

DATE: _________________ **DATE OF ISSUE:** _________________

NAME: ________________ **DATE OF ACTION:** __________________

WORK AREA: ___________________ **DATE RESOLVED :** __________________

CATEGORY

Medication event **Equipment related** **Patient related** **Environmental issues**

Health and Safety issues **Vehicle related** **Corporate compliance** **Miscellaneous**

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BRIEF DESCRIPTION OF OCCURANCE:

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ACTION TAKEN:

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INJURY **Patient**__________ **Staff**__________ **Unknown**__________

Person involved seen by physician? **Yes** **No**

Injured persons description if different from above:______________________________

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Signature of reporting person ___________ ________________ **Date**_____________

Signature of Team Leader ____________________________ **Date**_____________

Signature of C.E.O. If indicated _________________________ **Date**_____________

This is a confidential document