



Office Use	
Type of Incident: _____	
Injury: Y/N	Safety Protocol followed: Y/N
Education Provided: Y/N	
HR file: Y/N	

Patient Incident/Accident Report

Facility:	_____		
Employee Name:	_____	Full Time/PRN:	_____
	Job Title: _____	Length of Time in this Position:	_____
Supervisor Name:	_____		

Patient Information:	Patient Name:	_____	
Male/Female:	Patient Age:	Patient Weight:	_____
Patient	_____		
Diagnosis:	_____		

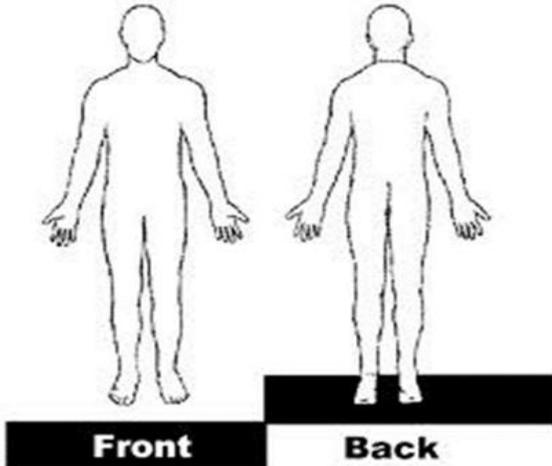
Today's Date:	_____		
Date of Incident:	_____		
Time of Incident:	_____	am	pm

Employee Statement of Incident:
 Include () What occurred () Why incident occurred () Equipment used () Location of incident

Was the patient injured?	Yes/No	Gait Belt in use?	Yes/No
--------------------------	--------	-------------------	--------

Signature of Employee _____ Date: _____

Location of Injury: (To be completed by Employee)



Type of Injury:

- 1. Laceration
- 2. Hematoma
- 3. Abrasion
- 4. Burn
- 5. Swelling
- 6. Skin Tear
- 7. None Apparent
- 8. Other (Specify below):

To Be Completed by Supervisor:

Supervisor Statement:

Signature of Supervisor _____ Date: _____

Was therapist following Physician approved POC, providing appropriate level of supervision & observing precautions?

Details if needed:

Was Employee Injured? Yes No *If yes, AD and HR must be notified immediately*

Was onsite medical care administered to the patient? Yes No

If Yes, type of care provided, by whom, & time provided:

Did patient require additional medical care? Yes No

If yes, provide details and attach any records or x-rays obtained :

Was Area Director Notified? Date: _____ How? (Circle) Email, Phone, Fax

Was Administration at Facility Notified? Yes No

Was Facility Incident/Accident Report Completed? Yes No

Was the Facility provided a copy of CTS incident report? Yes No

To Be Completed by Witness:

Statement of Witness to Patient Incident:

Describe the incident? What did you see, hear, do, etc?

Witness Signature _____

Date: _____

Corporate Office:

		AD Investigation Required?	Yes/No
Area Director Signature _____	Date: _____	If Yes, Report Completed?	Yes/No
		Clinical Investigation Required?	Yes/No
Clinical Specialist Signature _____	Date: _____	If Yes, Report Completed?	Yes/No
		<i>Did incident result in disciplinary action</i>	
President Signature _____	Date: _____	<i>for Employee?</i>	Yes/No
		<i>Disciplinary Action Taken:</i>	
Follow Up Required?	Yes/No	Investigation Completed?	Yes/No
<i>Details for Follow Up,</i>			
Liability Insurance Company Notified?	Yes/No		

Updated 6/25/2019

