**Medical Office Incident Report**

### **1. Title: Medical Office Incident Report**

### **2. Basic Information**

* **Report ID**: [Unique Identifier]
* **Date of Incident**: [DD/MM/YYYY]
* **Time of Incident**: [HH:MM AM/PM]
* **Location of Incident**: [Reception, Waiting Area, Exam Room, etc.]

### **3. Parties Involved**

* **Name of Affected Person**: [Patient, Employee, Visitor Name]
* **Role**: [Patient, Visitor, Employee, etc.]
* **Contact Information**: [Phone Number, Email Address]

### **4. Description of Incident**

* **Type of Incident**: [Fall, Accident, Patient Complaint, etc.]
* **Detailed Description of Incident**:  
  [Provide a clear, step-by-step description of the incident, including what happened, how it happened, and any immediate actions taken.]

### **5. Cause of Incident**

* **Possible Causes**:
  + [Wet Floors]
  + [Poor Signage]
  + [Equipment Malfunction]
  + [Other - Specify]

### **6. Immediate Actions Taken**

* **Immediate Response**: [First Aid, Relocation, Contacting Medical Staff, etc.]
* **Person(s) Notified**: [Name, Title, and Contact Information of People Informed]

### **7. Witness Information**

* **Name of Witness**: [Full Name]
* **Position/Title**: [Job Title]
* **Contact Information**: [Phone Number, Email Address]
* **Witness Statement**:  
  [Provide a summary of the witness's account of the incident.]

### **8. Corrective Actions and Preventive Measures**

* **Corrective Actions Taken**:
  + [Provide a description of steps taken to resolve the issue.]
* **Preventive Measures**:
  + [Procedural Changes, New Signage, etc.]

### **9. Signatures**

* **Prepared by (Name, Title, Date, Signature)**:
  + Name: [Full Name]
  + Title: [Position]
  + Date: [DD/MM/YYYY]
  + Signature: [Signature]
* **Reviewed by (Name, Title, Date, Signature)**:
  + Name: [Full Name]
  + Title: [Supervisor/Manager]
  + Date: [DD/MM/YYYY]
  + Signature: [Signature]