

# 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]