



INCIDENT REPORT

Instructions: This form is to be completed within established timeframes to report incidents that occur that put property or people at risk, present a clear danger, interrupt client/patient services, or raise risk to providing services and operations. Submit via email to your immediate supervisor and the Director of Human Resources. Attach a copy of applicable police report or insurance information to this form when submitting (if applicable).

Section A - to be completed by reporting personnel and forwarded to your immediate Supervisor/Director

Report prepared by _____ Title _____ Signature _____		
Forwarded to immediate Supervisor/Director Date & Time _____		
Reporting Department:		
<input type="checkbox"/> WC- _____ <input type="checkbox"/> HFPC <input type="checkbox"/> Admin <input type="checkbox"/> Boutique <input type="checkbox"/> MW!Ohio/Youth Services <input type="checkbox"/> Other _____		
Date of Incident _____	Time of Incident _____	
Type of incident		
<input type="checkbox"/> Critical Incident: police/fire/sheriff called, workplace violence, subterfuge activity, major injuries, threats, etc. Report to supervisor within 4 hours Were Police Called? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please request a police report and forward it to HR.		
<input type="checkbox"/> General Incident: Client/Patient/Visitor escalation, Minor injury, theft, damage/destruction of property, harassment, etc. Report to supervisor within 24 hours		
Location/Address where incident occurred (office, building, street, city, highway, mile marker, etc.)		
Weather Conditions (if applicable): <input type="checkbox"/> Clear <input type="checkbox"/> Raining <input type="checkbox"/> Snowing <input type="checkbox"/> Sleetng <input type="checkbox"/> Foggy <input type="checkbox"/> Other		
Description of incident (be specific and factual, use additional space if necessary)		
Were there any witnesses? <input type="checkbox"/> No <input type="checkbox"/> Yes – provide the following information		
Witness Name	Address	Telephone Number

Section B – to be completed by Immediate Supervisor/Director

Bodily Injury <input type="checkbox"/> Yes (reported not observed) <input type="checkbox"/> No		Name of Injured:	Age or Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
<input type="checkbox"/> Visitor <input type="checkbox"/> Client <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Student					
Injured Person Address	City	State	Zip Code	Telephone Number	
Describe Injury (List body parts, if applicable)		Was medical attention received? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Property Damage <input type="checkbox"/> Yes <input type="checkbox"/> No		What was damaged?			
Who is the owner? ENLC <input type="checkbox"/> Other <input type="checkbox"/>		Owner's Address		Owner's Telephone Number	
Other comments:					

Risk Assessments:

List policies and procedure in effect that relate to this incident:

Were policies & procedures followed No Yes
 Has corrective action been initiated? No Yes N/A

Describe:

What changes could be made to prevent this type of incident from happening in the future?

Department Director, if different:

Additional Comments by Dept Director, if applicable.

Notification made by Immediate Supervisor/Department Director to HR Director

Emailed Date _____ Time _____

Immediate Supervisor's name _____ Signature _____

Date and Time _____