Valley Radiology CONSULTANTS

EMPLOYEE INCIDENT OCCURRENCE REPORT FORM

Submit to COO AND HR within 24 hours of occurrence (use additional sheets as necessary)

DO NOT COPY THIS FORM: INTERNAL USE ONLY

I. OFFICE INFORMATION

Name of Office

Location Street Address City State Zip Code

Person/Supervisor Reporting Occurrence

II. EMPLOYEE INFORMATION (If Applicable)

Employee Name Employee Social Security #

Employee Street Address City State Zip Code

Paylocity ID # Employee Phone # Employee DOB

III. OCCURRENCE INFORMATION

Occurrence DATE and TIME

Reported on Date & Time

Location of Incident (ie; exam room, hallway)

Equipment being used during occurrence (If Applicable)

IV. PATIENT INFORMATION (If Applicable)

Patient Name Patient Phone #

Patient's ID # Pt Age Pt Gender

Patient's Street Addresss City State Zip Code

V. DESCRIBE CIRCUMSTANCES OF THIS OCCURRENCE (NARRATIVE OF FACTS ONLY)

VI. DESCRIBE INJURY, SPECIFIC BODY PART/ AREA & PAIN TYPE (if any)

Was this injury work related? ____YES ____NO Questionable Incident? ____YES ____NO

Were ANY Witnesses Present to this Incident? ____YES (Please list below) ____NO

1. Witness Name Phone # 2. Witness Name Phone # 3. Witness Name Phone #

VII. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this occurrence:

B) Describe corrective or proactive action(s) taken:

VIII. Sign below to acknowledge the information you provided on this form is accurate and true to the best of your knowledge.

SIGNATURE OF PERSON SUBMITTING REPORT PERSON'S NAME PRINTED PERSON'S JOB TITLE

DATE REPORT COMPLETED TIME REPORT COMPLETED SITE SUPERVISOR'S INITIALS DATE