

PRECISION MEDICAL GROUP

INCIDENT REPORT

Patient's Name: _____ D.O.B: _____

Date of Occurrence: _____ Time of Occurrence: _____

Location Of Occurrence: (i.e. pool deck, bathroom etc.) _____

Type of Incident: _____

Patient's Address: _____ City: _____ State: ____ Zip: _____

Patient's Phone: _____

Patient's Physician: _____

Physician's Phone: _____

Was M.D. notified? ____ When, and by whom? _____

Was patient being assisted at the time of incident? ____ If so, by whom? _____

Was any equipment being used at the time of incident? _____

Please specify: _____

What action, if any was taken? (i.e.; first aid etc.):

Description of incident:

Additional Comments:

Witnesses: _____

Report completed by: _____ Date of report: _____

Witness signature: _____ Print name: _____ Date: _____

Witness signature: _____ Print name: _____ Date: _____