Barren River
DISTRICT HEALTH DEPARTMENT

INCIDENT/COMPLAINT REPORT FORM
P-10

EMPLOYEE: Return this completed form to your supervisor as soon as possible.

Name of Person Involved ______ Today's Date ______

Address ______ City ______

Phone Number ______ Age ______ Date of Birth ______ Sex ______

Social Security Number ______ Date of Incident ______ Time ______

Exact Location of Incident ______

Type of Incident (Select all that apply)

- ☐ Clerical/Data Entry
- ☐ Communications
- ☐ Testing Process
- ☐ Result Reporting
- ☐ Safety
- ☐ Discrimination/Harassment
- ☐ Policy/Procedural Violations
- ☐ Adverse Drug Reaction
- ☐ Vehicle Accident
- ☐ Accidental Needle Stick
- ☐ Medication Error (Wrong: Route, Dosage, Medication, Schedule)
- ☐ Hazmat Exposure
- ☐ Medical Device Failure
- ☐ Other Significant Exposure

Individual Type Involved (Select all that apply)

- ☐ Employee
  * If employee is involved, please fill out Section A.
- ☐ Patient
  * Skip Section A
- ☐ Visitor
  * Skip Section A
- ☐ Volunteer
  * Skip Section A
- ☐ Other (Please specify) ______

Section A - Employee Involvement

1.) Was the employee doing their regular job duties? ☐ Yes ☐ No

2.) Were they observed by another employee? If so, who? ☐ Yes ☐ No Who? ______

3.) Was the situation observed only by an employee? ☐ Yes ☐ No

4.) Was protective equipment being used, if applicable? ☐ Yes ☐ No

If not used, why? ______

Section B - Description of Incident/Complaint

Description of Incident/Complaint (who, what, when, where, why, and how. Include sequence of events, personnel involved, body part injured, reason incident occurred.) (If medication error, include brand name, manufacturer, and dosage.) (Use additional form if necessary.)

Actions taken by staff members

Witness Name | Phone Number

Address

Witness Name | Phone Number

Address

Section C - Medical Information

Was medical attention sought? ☐ Yes ☐ No

Was treatment refused? ☐ Yes ☐ No First Treatment Date

Treating Physician | Phone Number

Address

First Day Off Work | Return to Work Date

Duties Restricted? ☐ Yes ☐ No Explain

Section D - Corrective Action Taken/Follow-Up

Description of Corrective Action/Follow-Up (list things that have been or will be taken to prevent a reoccurrence.)

Director Comments

Director Signature Date

Nursing Administrator Signature Date

Supervisor Signature Date

Complaintant Signature Date

Worker Compensation First Report Sent? ☐ Yes ☐ No Date Sent

OSHA 300.A Log # ☐ Yes ☐ No Date Sent

Section E - Statements of Understanding

I understand the potential risks related to the exposure to the incident that occurred and agree to receive an examination and/or treatment for the exposure, as recommended by my physician. This includes serological testing for Hepatitis B and the HIV virus as indicated.

I understand the potential risks related to the exposure incidents that occurred and DO NOT agree to have an examination or treatment for the exposure.

Employee Signature Date

Supervisor Signature Date

I understand the information above will be used by my employer to help determine liability for injury. I acknowledge that the above statements are true and accurate representation of the requested information.

Employee Signature Date

Job Title

Testing for HBV: Baseline and 6 months*

Testing for HIV: Baseline, 6 weeks, 3 months, 6 months, and 1 year**

Current references may be found on the CDC/NIOSH website *"Bloodborne Infectious Diseases: Management and Treatment Guidelines"* at: http://www.cdc.gov/niosh/topics/bbp/guidelines.html