Consumer/Employee/Visitor Incident Report

SECTION I – Description of the Incident
(To be filled out by the employee)

Report Submitted By: _____ **Title:** _____	**Date:** _____
Phone Number: _____ **Ext:** _____	
Date of Incident:_____	**Time/Shift:** _____
Address/Location of Incident: _____	

a) Type of Incident:

☐Abuse/Neglect
☐Biohazardous Accident
☐Bomb Threat
☐Communicable Disease
☐Evacuation/Lockdown
☐Elopement/Wandering
☐Equipment/Maintenance
☐Infection Control
☐*Injury – Consumer
☐*Injury – Staff
☐Medical Emergency
☐Medication Error/Issue
☐Obscene/Harassing Phone Call
☐Possession of Weapons
☐Request Transport
☐Sentinel Event
☐Sexual Assault/Assault
☐Slip, Trip, Fall ☐ On Ice
☐Suicide/Suicide Attempt
☐Use/Possession of Licit/Illicit Substance
☐**Vehicular Accident/Issue
☐Violence/Aggression/Threatening Behavior
☐Other:
_____
_____

b) Name each person involved in the incident (**use consumer ID if 42 CFR Part 2 applies**). Indicate the role of each person in the incident using the following abbreviations:

C = Consumer **E** = Employee **V** = Visitor **W** = Witness (if not already identified)

Name	Role	Comment/Notes

c) Describe how the incident/event occurred:

_____
_____
_____
_____

d) Name of the person that was immediately notified: _____

e) Supervisor's instruction's (if applicable):

_____
_____
_____
_____

FAIRBANKS NATIVE ASSOCIATION

Additional Comments:

Signature: _____ Date: _____

Note: If this incident involves an injury to an employee, regardless if they are seeking treatment or not, please have the staff member contact Alaska National Medcor at 1-800-553-8041 and file a report with the triage nurse.

**** If an injury occurred, complete the Injury/Illness Report Attachment***

*****If this is a vehicular accident, please also fill out a vehicle accident report.***

SECTION II – Department or Supervisor In Charge of Investigation
(To be filled out by the Supervisor)

1. Was the incident preventable? ☐ Yes ☐ No If yes, how?

_____
_____
_____

2. Did the employee take action after the incident? ☐ Yes ☐ No If yes, what action was taken?

_____
_____
_____

3. What action was taken to prevent future similar incidents?

_____
_____
_____

4. What follow up is needed?

_____
_____
_____

5. Who is responsible for follow up?

_____
_____
_____

6. Additional information:

_____
_____
_____

Your Name: _____ Date: _____
(Please Print)

Your Signature: _____

Date Reviewed by Program Director: _____

Additionally, the Program Supervisor is to notify appropriate agencies or authorities as required by law, grant, and contract or otherwise.

SECTION III – Program Health & Safety Representative Review/Follow-up
(To be filled out by the H & S Representative)

IMMEDIATE CAUSES – Check all that apply	
Substandard Acts/Actions	**Substandard Conditions**
☐Operating equipment without authority ☐Failure to warn ☐Failure to secure ☐Operating at improper speed ☐Making safety devices inoperable ☐Removing safety devices ☐Using defective equipment ☐Failure to use PPE ☐Failure to use Personal Traction Devices ☐Improper loading ☐Improper placement ☐Improper lifting ☐Servicing equipment in operation ☐Horseplay	☐Inadequate guards or barriers ☐Inadequate or improper protective equipment ☐Defective tools, equipment or materials ☐Congestion or restricted action ☐Inadequate warning system ☐Fire and explosion hazard ☐Poor housekeeping, disorder ☐Hazardous environmental conditions, gases, smoke, dusts, fumes ☐Noise exposure ☐Radiation exposure ☐High or low temperature exposure ☐Inadequate or excess illumination ☐Inadequate ventilation

☐Under influence of alcohol and/or other substances

Health & Safety Representative Comments:

_____

_____

_____

SECTION IV – Signatures

_____ _____
Program Health & Safety Representative Date

_____ _____
Program Director Date

_____ _____
Division Director Date

_____ _____
Executive Director Date

_____ _____
Health & Safety Coordinator Date

NOTE: ***Send completed original Incident Report to Health and Safety Coordinator <u>after</u> the Program Director and/or Division Director has signed off on the report.***

FAIRBANKS NATIVE ASSOCIATION
EMPLOYEE/CONSUMER/VISITOR
INJURY/ ILLNESS REPORT ATTACHEMENT

This form should be completed by the employee, supervising adult or visitor following all accidents, or incidents that occur within the programs jurisdiction or purview that:

1. Results in the injury of a student, or visitor.
2. Results in property damage.

Please complete the following form with as much detail as possible. Attach additional pages as necessary, including reports from witnesses. When completed attach to the FNA Incident Report Form. Please retain a copy for your records.

☐ Employee ☐ Consumer ☐ Visitor	Date of accident/incident: (MM/DD/YYYY)	Time of accident/incident: AM ☐ PM ☐

Name: (Last, First MI)

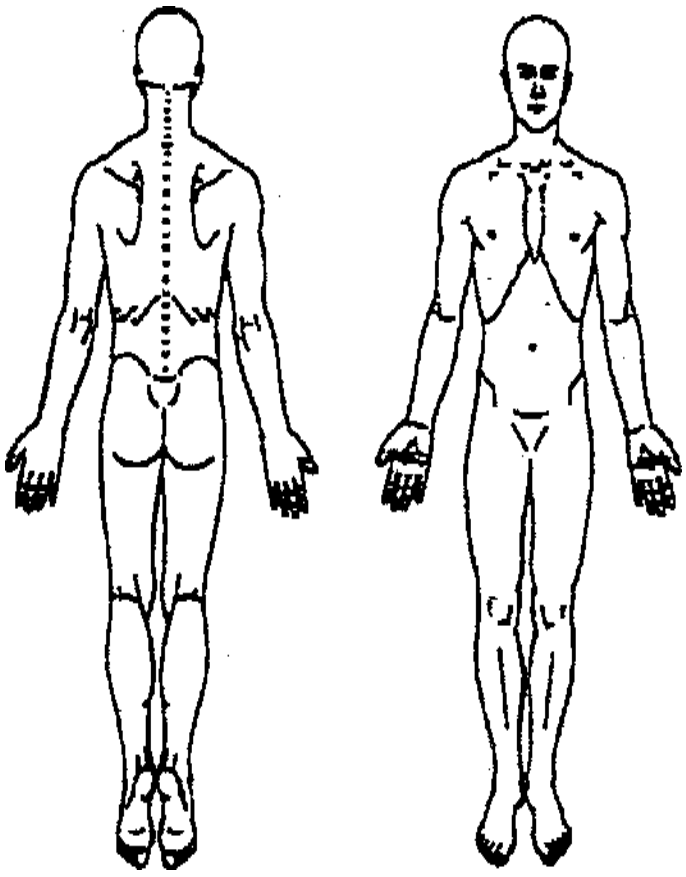
Phone Number:	Email Address:

Address:	City:	State:	Zip Code:

Accident/Injury location: (e.g. building, floor and room)

Body Part(s) Injured (Check <u>ALL</u> that apply <u>AND</u> circle the areas on the body diagram provided):

☐ Arm
☐ Abdomen
☐ Ankles
☐ Back
☐ Chest Ribs
☐ Ears
☐ Elbow
☐ Eyes
☐ Face
☐ Feet
☐ Fingers
☐ Full Body
☐ Groin
☐ Hand
☐ Head
☐ Hip
☐ Internal
☐ Knees
☐ Legs
☐ Mouth/ Teeth
☐ Neck/ Throat
☐ Nose
☐ Pelvis
☐ Shoulder
☐ Skin
☐ Toes
☐ Wrist
☐ Other _____



Type of Injury (Check all that apply)

☐ Abrasion
☐ Amputation
☐ Burn
☐ Chemical reaction
☐ Crush
☐ Cut/ Laceration
☐ Death
☐ Dislocation
☐ Fracture
☐ Puncture
☐ Shock/electrocution
☐ Sprain/ Strain

Please provide in as much detail as possible, a description of the accident/incident. Also, please provide names of witnesses (witness statements may be attached to this form).

Was first-aid rendered? ☐ Yes ☐ No	Have medical services been rendered to the Employee/Consumer/Student/ Visitor? If yes, please list location and by who: ☐ Yes ☐ No

Person Completing Report Signature: Date:

Contact information (if completed by someone other than the injured)

Name: Phone Number:

Supervisor Signature:	Date:

FOR INTERNAL USE ONLY

Received Date:

Received By:

H&S Coordinator Signature: