



Accident/Injury/Incident Report

Name: _____ Date: _____

Location/Department: _____ Time of Incident: _____

Member Guest Employee Other: _____

Address: _____ Age _____

Name of Guardian: _____ Phone Number: _____

*If individual is under 18

Description of Incident: _____

Incident Resulted In:

Injury No Injury Medical Treatment

Illness Property Damage Other: _____

Witnesses:

1.) Name: _____ Phone Number: _____

2.) Name: _____ Phone Number: _____

Incident Handled By: _____ Department: _____

Person Completing report: _____ Department: _____

Actions Taken to Handle Incident: _____

Medical Attention Provided:

Individual accepted Ambulance: Yes No

Individual denied further treatment offer: Yes No

*No medical attention was desired and/or required.

Signature: _____ Date: _____

(Signature required by injured person or guardian, if under the age of 18)

AREA TO BE COMPLETED BY HEALTHQUEST MANAGEMENT

Follow up call made: Yes No

Date of call: _____ Time of call: _____

Comments From Call: _____

Measures Taken to Avoid Similar Incidents: _____

