INCIDENT OR UNUSUAL OCCURRENCE REPORT

Name of Person Completing Report ___________________________
Date Report Completed ____________ Time Report Completed ________

NATURE OF INCIDENT:  ☐ Member Injury     ☐ Patient Injury
☐ Bystander Injury     ☐ Needle/Sharp Stick
☐ Blood/Body Fluid Exposure
☐ Known/Suspected Communicable Disease Exposure
☐ Malfunction of Medical Equipment
☐ Ambulance Vehicle Breakdown
☐ Unusual Occurrence
☐ Other __________________________

Date of Incident _______________    Time of Incident ___________________
Date and Time Reported to Officer in Charge __________________________
Location of Incident ______________________________________________
Ambulance Run Number (As Applicable) ______________________________

Describe Incident in Full:

Signature of Person Completing Form __________________________ Date ________

Signatures of Witnesses to Incident:
Print Name ______________________________ Sign ______________________________ Date ____________
Print Name ______________________________ Sign ______________________________ Date ____________

Signature of Officer Receiving Report __________________________ Date ________
INJURY REPORT

Name of Injured Person __________________________

Describe Injury in Full:

Describe Treatment Given by Ambulance Crew:

Follow-up Treatment:

☐ Admitted to hospital _________________
☐ Treated at ____________ ED and released
☐ Refused Treatment by Ambulance Crew
☐ Refused treatment at Hospital
☐ Treated at ____________ ED but refused admission AMA
☐ Treated by Clinic/Private Physician __________________________
☐ Other ______________________________________________________

Reported to Worker’s Compensation Insurance Company (As applicable)
Date ________________________  By Whom ______________________

Follow-up Information:
Needle/Sharp Stick - Blood/Body Fluid Exposure

Name of Person Exposed ____________________________________
Date this report is being completed ________________
Name of Person Completing Report ___________________________
Date Exposure Reported to Designated Officer _________________

Exposure Record:
Date __________________________  Time ___________________________

Job/Duty being performed by worker at time of exposure:

Details of Exposure
- Type of Fluid or Material ________________________________________
- Amount of Fluid or Material ________________________________________
- Severity of Exposure (For percutaneous exposure, give depth of injury & whether fluid was injected; For mucous membrane or skin exposure, state extent and duration of contact, and the condition of the skin, i.e., intact, abraded, chapped, etc.)

- Source Individual Tested for HBV/HIV? ☐ Yes* ☐ No ☐ Consent Not Obtained
  *Results of testing of source’s blood will be made available ASAP to the exposed member, and the member will be informed of the applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

Member referred for follow-up testing and/or treatment? ☐ Yes ☐ No
Suspected Communicable Disease Contact
Not for Blood/Body Fluid Exposure

Give as many details as are available at the time you are completing this report:

Hospital to which patient was transported ___________________________
Date hospital Infection Control Nurse was contacted __________________
Name of Infection Control Nurse ___________________________________

Follow-up recommended and record of follow-up: