Incident Report Form

Date:

Name:

date of incident and name(s) of individual(s) involved

Within 24 hours of the incident report the situation to the Executive Director or a Board Member in person, by phone, text, or email regarding the incident. The incident report form must be completed, and it should be on file with both the program lead and our administrator (for insurance reference purposes).

This is a Word document fillable form. In Word, simply click on the gray area to check the appropriate box or to begin typing text. Text areas will expand and there is no limit to what you may write. Please be as complete as possible in your descriptions. Don’t worry about overflowing to additional pages.

Please print or save as pdf and give / send completed form the Executive Director and Administrator.

Incident Information

|  |  |  |
| --- | --- | --- |
| DAY OF WEEK**[ ]**  M **[ ]**  T [ ]  W **[ ]** TH **[ ]**  F **[ ]** S **[ ]**  SU | TIME      **[ ]** AM **[ ]**  PM | DID INCIDENT OCCUR ON NEXT STEP PREMISES?**[ ]**  Yes **[ ]** No |
| location of incident (if possible, take pictures and email to director and administrator      |
| description of incident (a brief factual account of the incident; including who was involved, how the incident occurred and what action was / is being taken in response to the incident)      |

Witness Information

|  |  |
| --- | --- |
| NAME      | DAYTIME BEST CONTACT PHONE      |
| ADDRESS      | EMAIL      |
| NAME      | DAYTIME BEST CONTACT PHONE      |
| ADDRESS      | EMAIL      |

Claimant Information

|  |  |
| --- | --- |
| NAME OF INJURED PARTY      | **[ ]**  EMPLOYEE **[ ]** CLIENT **[ ]**  VOLUNTEER **[ ]**  VISITOR**[ ]** OTHER       |
| NAME OF PARENT OR GUARDIAN (IF APPLICABLE)      | RELATIONSHIP      |
| ADDRESS STREET      | CITY, STATE, ZIP      |
| HOME PHONE **[ ]** BEST CONTACT      | CELL PHONE **[ ]**  BEST CONTACT      | EMAIL **[ ]** BEST CONTACT      |
| WERE INJURIES OR WERE POLICE INVOLVED (IF YES, PLEASE DESCRIBE)      |
| TRANSPORTED BY AMBULANCE / EMT**[ ]**  YES **[ ]**  NO | NAME OF HOSPITAL / CLINIC / DOCTOR, IF APPLICABLE      |

Observations

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| DESCRIBE CLAIMANTS DEMEANOR WHEN MAKING THIS REPORT (AGITATED, IN OBVIOUS PAIN, ABLE TO MOVE AROUND WHILE DESCRIBING WHAT HAPPENED, ETC.      |
| ANYTHING ELSE YOU BELIEVE TO BE RELEVANT OR IMPORTANT?      |

Follow Up Actions / Conversations

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| DESCRIBE ANY FOLLOW UP ACTIONS OR CONVERSATIONS WITH THE CLAIMANT OR OTHERS YOU HAVE HAD SINCE THE INCIDENT      |

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| NAME OF INDIVIDUAL COMPLETING THIS FORM      | SIGNATURE (IF PRINTING DOCUMENT) | DATE      |