

**INCIDENT REPORT**

DUTY STATION		FDR NUMBER	
ADDRESS			
CITY		STATE	ZIP CODE
DATE OF REPORT		DATE OF INCIDENT	
<b>TYPE OF INCIDENT</b> Initial <input type="checkbox"/> Follow-up <input type="checkbox"/> YES NO 1. Employee Injury <input type="checkbox"/> <input type="checkbox"/> 2. Patient Injury <input type="checkbox"/> <input type="checkbox"/> 3. Visitor Injury <input type="checkbox"/> <input type="checkbox"/> 4. Medical Device Injury <input type="checkbox"/> <input type="checkbox"/> 5. Property Damage <input type="checkbox"/> <input type="checkbox"/> 6. Hazardous Condition <input type="checkbox"/> <input type="checkbox"/>		<b>SEVERITY</b> <input type="checkbox"/> 1. Fatal <input type="checkbox"/> 2. Hospitalized <input type="checkbox"/> 3. Ambulatory <input type="checkbox"/> 4. No Treatment  LOST TIME (days) _____	
		<b>DISABILITY</b> <input type="checkbox"/> 1. Temporary <input type="checkbox"/> 2. Partial Permanent <input type="checkbox"/> 3. Full Permanent <input type="checkbox"/> 4. None	
<b>SERIOUS INCIDENT TYPE</b> (Check one) <input type="checkbox"/> 1. Fatal <input type="checkbox"/> 2. More than 3 injured <input type="checkbox"/> 3. Property damaged > \$25,000. <input type="checkbox"/> 4. Aircraft <input type="checkbox"/> 5. Radiation Release <input type="checkbox"/> 6. Biological Release			
EXAMINED BY PRIMARY CARE PROVIDER <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDICAL EXPENSE INCURRED: <input type="checkbox"/> YES <input type="checkbox"/> NO	
INVESTIGATION CONDUCTED BY:		ESTIMATED COST: \$ _____	
		PHONE NUMBER ( )	
<b>INDIVIDUAL INVOLVED</b>			
NAME		TORT POSSIBLE <input type="checkbox"/> YES <input type="checkbox"/> NO	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ADDRESS			
CITY		STATE	ZIP CODE
PHONE NUMBER ( )		TIME OF INCIDENT	
<b>EMPLOYEE</b>			
JOB TITLE		OWCP FORM FILED <input type="checkbox"/> YES <input type="checkbox"/> NO	
PERSONNEL STATUS - CO, GS, WG, TRIBAL, VOLUNTEER, OTHER		GRADE LEVEL / STEP	
NUMBER OF DEPENDENTS (Spouse and Children under 18)		SUPERVISOR'S NAME	
WORK PHONE NUMBER ( )		SHIFT ONE, TWO, OR THREE <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	TIME ON DUTY BEFORE INCIDENT
<b>PATIENT</b>			
DATE OF ADMISSION	DEPARTMENT	DEPARTMENT PHONE NUMBER ( )	CHART NUMBER
DIAGNOSIS ON ADMISSION		MEDICAL DEVICE RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO	
CONDITION BEFORE INCIDENT			
MEDICATIONS ADMINISTERED <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF MEDICATION	
COMMENTS			
<b>VISITOR</b>			
PURPOSE OF VISIT			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
Indian Health Service

**INCIDENT REPORT**

PROPERTY			
OWNER		PRIVATE PROPERTY <input type="checkbox"/> YES <input type="checkbox"/> NO	
ADDRESS			
CITY		STATE	ZIPCODE
PROPERTY MANAGEMENT NOTIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE	NATURE AND EXTENT OF DAMAGE	
ESTIMATED REPAIR / REPLACEMENT \$ _____	GOVERNMENT VEHICLE INVOLVED <input type="checkbox"/> YES <input type="checkbox"/> NO	REGISTRATION / TAG NUMBER	

**NARRATIVE**

Give a factual description of incident, location, and other important specifics [ie. body parts(s), other individual involved, etc.]

FACILITY NAME: \_\_\_\_\_ DEPARTMENT: \_\_\_\_\_

DESCRIPTION:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DIAGRAM OF INCIDENT

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CODING SECTION		
INCIDENT LOCATION CODE	DESCRIPTION	
OSHA TYPE CODE	IHS TYPE CODE	
OSHA SOURCE CODE	ICD NATURE CODE	
OCCUPATION CODE	ICD EXTERNAL CAUSE CODE	
OSOP AGENCY CODE		
SIGNATURE AND TITLE OF REPORTING EMPLOYEE	DATE	PHONE (    )
SIGNATURE AND TITLE OF REVIEWING OFFICIAL	DATE	PHONE (    )
SIGNATURE AND TITLE OF CODING OFFICIAL	DATE	PHONE (    )

The information collected on this form is to be utilized in compliance with the Privacy Act of 1974.