[NAME OF AGENCY
[ADDRESS OF AGENCY]

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: