

INCIDENT REPORT

CASE NUMBER		DUTY STATION		FDS NUMBER	
ADDRESS					
CITY				STATE	ZIP CODE
DATE OF REPORT			DATE OF INCIDENT		
TYPE OF INCIDENT 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"/>		SEVERITY <input type="checkbox"/> 1. Fatal <input type="checkbox"/> 2. Hospitalized <input type="checkbox"/> 3. Ambulatory <input type="checkbox"/> 4. No Treatment LOST TIME (days) _____		DISABILITY <input type="checkbox"/> 1. Temporary <input type="checkbox"/> 2. Partial Permanent <input type="checkbox"/> 3. Full Permanent <input type="checkbox"/> 4. None	
SERIOUS INCIDENT TYPE (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		ESTIMATED COST: \$ _____	
INVESTIGATION CONDUCTED BY:				PHONE NUMBER ()	
INDIVIDUAL INVOLVED					
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		
EMPLOYEE					
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
PATIENT					
DATE OF ADMISSION		DEPARTMENT		DEPARTMENT PHONE NUMBER ()	
DIAGNOSIS ON ADMISSION				CHART NUMBER	
CONDITION BEFORE INCIDENT				MEDICAL DEVICE RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO	
MEDICATIONS ADMINISTERED <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF MEDICATION		
COMMENTS					
VISITOR					
PURPOSE OF VISIT					

