Temple University Nursing Department

General Incident Report Form

Directions: This form should be completed by the faculty/student within 24 hours after an incident occurs; and should be submitted to the clinical coordinator.

Student Name: __________________________  Student ID: __________________________

Date of Incident: __________________________  Date of Report: __________________________

Place Incident Occurred (specify facility and unit/department): ________________________________

Person(s) involved in the Incident: _______________________________________________________

Instructor/Preceptor/ Supervisor Name: ___________________________________________________

Describe the Incident:

Detail what equipment was being used (if applicable):

Initial Action(s), such as flushing, washing, medical care, etc…:

Describe planned follow-up action(s), such as medical care, etc.:

Signature of Faculty/Student: __________________________  Date __________________________

Phone Number: __________________________

E-mail Address: __________________________