

# North Shore



## MEDICAL INCIDENT REPORT FORM

NAME: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_

LOCATION OF ACCIDENT: \_\_\_\_\_

\_\_\_\_\_

DESCRIPTION OF INJURY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ACTION TAKEN: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FOLLOW UP ACTION NEEDED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

POSITION: \_\_\_\_\_