Flagler County

EMPLOYEE INCIDENT REPORT FORM

Employee Name: _____

Address: _____ Age: _____ ☐ Male ☐ Female

City, State, Zip: _____ Phone: _____

NOTE: All incidents not consistent with the routine operation of Flagler County BCC or the routine care of the patient must be reported immediately to your supervisor and followed up within 24 hours with a written report to the department head.

Client Name: _____ Age: _____ ☐ Male ☐ Female

Address: _____

City, State, Zip: _____ Phone: _____

Location of incident: _____

Date of Incident: _____ Time of Incident: _____ am / pm

Explain/describe circumstances of incident (Continue on additional page if necessary): _____

Name(s) of person(s) involved (other than employee/client)

	NAME	
	ADDRESS	
	PHONE NUMBER	

Action taken: _____

Medical Assistance was: ☐ Not Applicable ☐ Accepted ☐ Refused

Medical Information: Hospital _____

Physician _____ Phone _____

Supervisor Notified: _____ Date: _____

Employee Signature: _____ Date: _____

Please complete this form and return to Human Resources with other necessary documentation within 24 hours after the incident.