QUALITY ASSURANCE OCCURRENCE REPORT FORM (UPDATED 3/12)

Date of occurrence: ___________________________  Time: _______  □ AM  □ PM
Location of occurrence: ________________________________________  □ IL  □ AZ

Is this:  □ A laboratory  □ Outdoors  □ Off campus  □ Student housing  □ MWU clinic

Occurrence involved (check box): □ Student □ Intern/Resident □ Faculty/Staff □ Visitor
  □ Patient □ Other ________________________________

Did the occurrence involve? (check all that apply) □ Near miss (could have resulted in injury, but didn’t)
  □ An instrument/device. If so, what instrument/device? ________________________________
  □ Contact with blood/other bodily fluids.
  □ Exposure to chemical, biological/rDNA, or radioactive material. If so, what?__________
  □ An animal bite/scratch/exposure. If so, what animal? ________________________________
  □ A fall, slip, or trip.
  □ A motorized vehicle. If so, a University vehicle? □ Yes  □ No  □ Not sure

Brief description of occurrence (state only facts): ________________________________
______________________________________________________________________________

Was anyone injured? (check one) □ Yes  □ No  □ None apparent

Name of person injured: __________________________________________________________
Address: _____________________________________________________________
Phone Number(s): __________________________________________________________
Date of birth: ________________  Male ______  Female ______

Injury type (check all that apply): □ Burn □ Contusion/bruise □ Cut/stick/abrasion □ Sprain/Strain
□ Fracture/dislocation □ Other: ____________________________________________

Action taken (check all that apply): □ Physician contacted □ Ambulance/EMT called □ First aid
□ Dressing □ Band aid □ Ice □ Splint □ Flush □ Other: ______________________________

Name of physician/hospital (if applicable): ______________________________________
Address/Contact number: _____________________________________________________

□ Check here if treatment was refused

Witnesses (including phone numbers): __________________________________________
______________________________________________________________________________

Signature of injured party (if possible)____________________________________________ Date________

Name of person completing form_________________________________________________
Contact Number of person completing form _________________________________________
Signature of reviewer __________________________________________________________ Extension_________________