Occurrence Report

EMS Provider Name:	***Date and Time of Occurrence:***
Mailing Address:	***Location of Occurrence:***
Social Security Number:	***Sex: M F*** ***Age:***

Activity Involved: *(If exposure to Blood or Body Fluids complete NCEMS FORM 2.11.2 also.)(If IV or Drug Box Incident, complete TEMS Pre—Hospital Drug & IV Incident Report also.)*

- ☐ Moving Vehicle
- ☐ Stationary Vehicle
- ☐ Portable Equipment
- ☐ Lifting Patient
- ☐ Lifting Other
- ☐ Invasive Procedure/Injection
- ☐ Hazardous Substance/Infectious Exposure
- ☐ Medication Administration
- ☐ Medical Procedure
- ☐ Other *Explain:*_____

Did Personal Injury Occur? ☐ Yes ☐ No
Did Property Damage Occur? ☐ Yes ☐ No

Did Other Personal Injury Occur? ☐ Yes ☐ No
☐ Volunteer ☐ Student ☐ Employee
☐ Patient ☐ Civilian

Type of Injury
- ☐ Laceration/Abrasion
- ☐ Needle/"Sharps" Stick
- ☐ Burn
- ☐ Bruise/Crush
- ☐ Bite/Scratch
- ☐ Electrical Shock
- ☐ Foreign Body
- ☐ Fracture
- ☐ Amputation
- ☐ Infection
- ☐ Other *Explain:*_____

Part of Body
- ☐ Head
- ☐ Eye
- ☐ Ear
- ☐ Face
- ☐ Neck
- ☐ Chest
- ☐ Abdomen
- ☐ Back
- ☐ Arm
- ☐ Shoulder
- ☐ Elbow
- ☐ Hand
- ☐ Finger(s)
- ☐ Wrist
- ☐ Leg
- ☐ Groin
- ☐ Knee
- ☐ Foot
- ☐ Toe(s)
- ☐ Ankle

Type of Property Damage
- ☐ Ambulance
- ☐ Zone Car
- ☐ Civilian Vehicle
- ☐ Building/Structure
- ☐ Portable Equipment
- *Explain:*_____
- ☐ Other
- *Explain:*_____

Patient Treatment Event
- ☐ Dose/Rate related
- ☐ MD Order related
- ☐ Incorrect Med Given
- ☐ Admin Route Related
- ☐ Med Not Administered
- ☐ Adverse Med Reaction
- ☐ Time Related
- ☐ Other
- *Explain:*_____

Possible Causes?
- ☐ Unclear as to Policy/Procedure
- ☐ Unaware of Safety Hazard
- ☐ Poor Illumination
- ☐ Foreign Material on Floor
- ☐ Building/Premises Defect
- ☐ Lifting/Pushing/Pulling
- ☐ Lack of Personal Protective Equipment
- ☐ Defective Equipment
- ☐ Combative Patient
- ☐ Other *Explain*_____

Supervisor Notified at Time of Occurance?
- ☐ No
- ☐ Yes *(name)*_____

Incident Witnessed?
- ☐ No
- ☐ Yes *(name)*
_____

Description of Occurrence:_____
_____
_____
_____
_____

EMS PROVIDER SIGNATURE_____
DATE FORM COMPLETED _____

SUPERVISOR TO FILL IN ALL ITEMS BELOW

Finding, Recommendations/Actions, Measures Taken to Prevent Reoccurrence, Other s Notified: _____
_____
_____
_____
_____

Treatment
- ☐ No Treatment Necessary
- ☐ First-Aid
- ☐ Emergency Room
- ☐ Workers Comp Physician
- ☐ Refused Treatment
- ☐ Other *Explain:*_____

Briefly Describe Treatment:_____
_____
_____
_____
*Rendered by:*_____
SUPERVISOR_____
DATE REPORTED TO EMS DIRECTOR _____
STATION LIAISON NOTIFIED ☐ Yes ☐ No

Disposition
- ☐ Returned to Work
- ☐ Released to Home
- ☐ Hospitalized
- ☐ Fatality
- ☐ Other
Explain _____