FULL RANGE
PHYSICAL THERAPY, LLC

Incident Report

This form is to be used to document all incidents, injuries, and / or illnesses whether officially reportable or not, as well to document the investigation. Please complete within 24 hours of the incident.

SECTION A: TO BE COMPLETED BY PERSON INVOLVED

Name/Title: _____ Contact Number: _____

DETAILS OF THE INCIDENT (Please circle Yes or No)

Date injury / incident occurred: _____ Time injury / incident occurred: _____

Was the injury / episode work related? Yes ☐ No ☐

Was a FRPT employee injured as a result of the incident? Yes ☐ No ☐

Was medical treatment sought? Yes ☐ No ☐

If yes, please provide the physician's contact information:

Name: _____ Phone: _____

Was a FRPT patient involved? Yes ☐ No ☐

If yes, please provide patient's contact information:

Name: _____ Phone: _____

Was another FRPT employee involved? Yes ☐ No ☐

If yes, what is the employee's name? Name: _____

Was anyone other than a FRPT employee or patient injured? Yes ☐ No ☐

Location where injury / accident occurred: _____

Part of body affected: _____ Nature of injury: _____

Aggravation of previous injury / medical condition: _____

Type of incident which caused injury: _____

NOTE: IF ADDITIONAL ROOM IS NEEDED. PLEASE SUPPLY ADDITIONAL PAGE(S) TO ENSURE A DETAILED REPORT.

SECTION B: TO BE COMPLETED BY THE PERSON INVOLVED AND REVIEWED BY SUPERVISOR WITHIN 48 HOURS

*****THIS IS AN EXTREMELY IMPORTANT SECTION AS THE AIM OF THE INCIDENT INVESTIGATION IS TO IDENTIFY PREVENTATIVE ACTION THAT WILL AVOID RECURRENCE*****

If reporting an incident, please describe how the incident occurred: _____

_____

_____

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_____

_____

_____

_____ _____
Supervisor Signature Date

_____ _____
Printed Name Title

_____ _____
Person Involved Signature Date

_____ _____
Printed Name Title

NOTE: IF ADDITIONAL ROOM IS NEEDED. PLEASE SUPPLY ADDITIONAL PAGE(S) TO ENSURE A DETAILED REPORT.