All Generations Home Care, Inc.

CLIENT REPORT OF INCIDENT / ACCIDENT

Please print legibly

Name of person completing report:_____ Title:_____

Date of report: _____ Were you present at the time of the Incident/Accident? ☐ Yes ☐ No

Client Name		Date of Birth			
Address					
City		State: MN	Zip		

1.	Date of injury:		Time of injury:	AM PM
2.	Address where injury occurred:			

3.	Description of incident/accident/injury and part of body affected if applicable. Please describe below:			
4.	Did the client seek medical attention? (please select): ☐ Yes ☐ No Date:			
	Name of medical facility		Phone Number	
	Physician		City	
	Address		State/Zip	
5.	Did the client treat themselves? ☐ Yes ☐ No If yes, please state any treatments they have done to date:_____			
6.	Did you report this injury to anyone (please select): ☐ Yes ☐ No			
	If so to whom:		Date/Time:	
7.	Were there witnesses? (please select) ☐ Yes ☐ No If yes, please provide information below:			
	Witness 1 Name		Phone	
	Address, City/State/Zip			

	Witness 2 Name		Phone	
	Address, City/State/Zip			

8.	**ANALYSIS** Place a check in the appropriate box and detail your findings in the explanation section.	
a.	Were any unsafe conditions present? If yes, explanation required.	☐ Yes ☐ No
b.	Were all safety rules being followed? If no, explanation required.	☐ Yes ☐ No
c.	Was the equipment in good working condition? If no, explanation required.	☐ Yes ☐ No ☐ NA
d.	Was the employee performing an unsafe act? If yes, explanation required.	☐ Yes ☐ No ☐ NA
e.	Was the employee working within the job description? If no, explanation required.	☐ Yes ☐ No ☐ NA
f.	Was the employee following agency policies? If no, explanation required.	☐ Yes ☐ No ☐ NA
g.	Was the employee injured in this occurrence? If yes, was it reported?	☐ Yes ☐ No
If your response to any of the analysis questions require an explanation please do so in this space:		

Signature of person completing report | Date

Return completed form to Safety Coordinator-Lori Mortensen within 24 hours of incident

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FOR OFFICE USE ONLY:

9.	Was the client referred to seek medical attention? ☐ Yes ☐ No
	If yes, describe referral process and follow up if needed:_____ _____ _____ _____ _____
10.	Based on the causes listed above, indicate what corrective actions will be taken to prevent a recurrence of this type of accident:_____ _____ _____ _____ _____

_____ _____

Safety Coordinator Signature | Date