SINCERE CARE AGENCY INC.
ACCIDENT/INCIDENT REPORT

DATE OF OCCURRENCE: **Other:**		**TYPE:** ☐**Employee** ☐**Patient** ☐
LOCATION OF OCCURRENCE: ☐Office ☐Field ☐Patient's Home ☐Other:		
Name:		Date of Birth:
Address:		Telephone No.
Individual Discovering Accident/Incident:		
Date and Time of Discovery:		
Description of Accident/Incident/Injury:		
Was there any equipment/structural hazards involved? ☐No ☐Yes If Yes, explain:		
Individuals involved:	Address/Telephone #:	E=Employee P=Patient O=Other
1.		
2.		
3.		
4.		
Witness:	Address/Telephone #:	E=Employee P=Patient O=Other
5.		
6.		
7.		
8.		
Description of Accident/Incident:		
Was involved individual seen by a Physician? □Yes □No If Yes, Date/Time:		
Was medical intervention required? □Yes □No If Yes, Describe:		
If employee, are there any resulting work restrictions? □Yes □No		
If Yes, Describe:(Attach Physician Report)		
Signature/Title:		Date: