Incident Report
C O N F I D E N T I A L

* INSTRUCTIONS: This Incident Report Form is used to report adverse incidents or injuries that occur to members, visitors, or associates. **Incident Reports must be sent to the UHP Risk Manager within one day of the date of the incident.** Do NOT make copies of this report.

PERSON INJURED			
Last Name, First Middle Initial	Date of Birth	☐ Male	☐ Female
☐ Associate	☐ Visitor	☐ Member	
Street Address		Member ID #	
City, State, Zip Code		Contact Number	

DETAILS OF INCIDENT			
Date of Incident:	Time of Incident:		
Admission Date:	Time of Admission:		
Location (Be specific and include facility name, street address, building number, floor, direction such as NE corner, etc.)			
Diagnosis and diagnosis codes	Is additional information attached?	☐ Yes	☐ No
Clear and concise description of incident. (Who, What, When, How, Physical Findings)			

WITNESS(ES)		
Last Name, First Middle Initial	Street Address	City, State, Zip
Last Name, First Middle Initial	Street Address	City, State, Zip

PHYSICIAN or HOSPITAL INFORMATION					
Physician notified?	☐ Yes	☐ No	Hospitalized?	☐ Yes	☐ No
If yes, complete the following:	Name of Physician or Facility				
	Street Address				
	City, State, Zip				
	Summary of physician's recommendation, if applicable.				

PERSON COMPLETING REPORT		
Last Name, First Middle Initial	Position/Department	Telephone Number
Signature	Date	Time

DO NOT WRITE BELOW THIS LINE

HUMAN RESOURCES		
Summary and Disposition:		
Last Name, First Middle Initial	Title	Date:

RISK MANAGER		
Last Name, First Middle Initial	Title	Date: