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**

---

**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:_____<br>_____<br>_____<br>_____<br>_____ |
| 10. | Based on the causes listed above, indicate what corrective actions will be taken to prevent a recurrence of this type of accident:_____<br>_____<br>_____<br>_____<br>_____ |

_____ _____

Safety Coordinator Signature | Date