Banner Health

Banner Center for Health Careers

Student/Faculty Incident Form

BANNER HEALTH INTERNAL USE ONLY

To be completed by Banner Clinical Staff no later than end of shift on day of incident

Facility Where Incident Occurred: _____

STUDENT/FACULTY INFORMATION

Date of Incident _____ **Time of Incident:** _____ **Date Reported to Supervisor:** _____

Is the person in question (Please check one) ☐ **Student** ☐ **Faculty**

Student/Faculty Name _____ **DOB:** _____ **Phone:** _____

Address: _____ **City** _____ **State** _____ **Zip Code** _____

School: _____ **School Contact** _____ **Phone:** _____

Unit Manager/Preceptor: _____ **Phone:** _____

INCIDENT INFORMATION

If this is related to an injury, please ensure proper care is provided to student/faculty

****If this is a suspected impairment incident immediately escort Student/Faculty to Occ. Health for "for cause" testing. (ED if after hours)***

DESCRIBE THE INCIDENT AND ACTIONS TAKEN

Witness: _____ **Phone:** _____ **Witness:** _____ **Phone:** _____

If incident is patient related, was the patient sedated and/or combative? ☐ **Yes** ☐ **No**

REFUSED TREATMENT: ☐ **Yes** ☐ **No**

COMPLETED BY: _____ **TITLE** _____ **DATE:** _____

_____**To be completed by Banner Center for Health Careers Department only**_____

Student/ Faculty will: ☐ **CONTINUE** ☐ **NOT CONTINUE** **with clinical experience.**

RECOMMENDATION/NOTES