PARKLAND COLLEGE

INCIDENT REPORT		Date of Report	
Clinical Site Name		Phone (xxx-xxx-xxxx)	
Clinical Site Address		City, State, Zip	
Instructor Name		Phone (xxx-xxx-xxxx)	
Did you notify the Program Director?	☐Yes	☐No	

Program Name

☐	Certified Nurse Assistant (CNA)	☐	Massage Therapy (MSG)	☐	Respiratory Therapy (RTT)
☐	Dental Hygiene (DHG)	☐	Medical Assisting (MAS)	☐	Surgical Technology (SUR)
☐	Emergency Medical Services (EMS)	☐	Occupational Therapy (OTA)	☐	Veterinary Technician (VTT)
☐	Practical Nursing (LPN)	☐	Nursing (NUR)	☐	Radiology Technician (XRA)

Student Full Name		Student ID#	
Student Address		City, State, Zip	
Student Email Address		Phone (xxx-xxx-xxxx)	

Date of Incident		Time of Incident (include AM or PM)	
Witness #1		Witness Phone	
Witness #2 (optional)		Witness Phone	

Description of Incident:

What was the student doing when the incident/exposure occurred?		
How did the incident/exposure occur?		
What was the injury or illness? List the part of the body affected and explain how it was affected.		
What object or substance, if any, directly harmed the student?		
What was the immediate action taken?		
What PPE was being worn?		
Was an incident report completed at the clinical site?	☐Yes	☐No

If treatment was given away from the clinical site, list the name and address of the place it was given.

Treatment Site		Treatment Date	
Treatment Address		City, State, Zip	

Administrative Use Only: Date Hepatitis B vaccine series completed _____