



Adverse Occurrence Report

Original Date: April 2014

Reviewed: Annually

Last approved: May 2024

Date of incident: _____ Time: _____ AM/PM

Name of injured person: _____

Address: _____

Phone Number: _____

Date of birth: _____ Male _____ Female _____

School name: _____

Type of injury: _____

Details of incident: _____

Injury requires physician/hospital visit? Yes ___ No ___

Name of physician/hospital: _____

Address: _____

Physician/hospital phone number: _____

Signature of injured party

Date

*No medical attention was desired and/or required:

Signature of injured party

Date

Form must be forwarded and reviewed by simulation center Director within 24 hours of incident.