X-RAY INCIDENT REPORTING FORM
(Please type form)

FACILITY INFORMATION

Name of Facility: ____________________________________________________________
Facility Type: ___________________________________________ X-Ray Registrant #: _________________
Address: __________________________________________________________________
City: __________________________ State: ____________ Zip Code: _______________
Person Reporting Incident: _______________________________________________ Title: ______________________________
Contact Person(s): __________________________ Contact Phone #: ______________________________
Fax #: __________________________ Email Address: ______________________________

PATIENT / REPORTING INFORMATION

Date: _______ Time: _______ a.m. /p.m. Reported to Healthcare Facility Regulation Division
Date: _______ Time: _______ a.m. /p.m. Facility Was Aware of the Incident
Date: _______ Time: _______ a.m. /p.m. Incident Occurred

Affected Patient or Employee Name __________________________ Age __________ Sex __________ Date of Birth ________________

Patient Med Rec # (as applicable) __________________________ Date of Admission __________________________

Patient’s Diagnosis

TYPE OF INCIDENT: Please check appropriate boxes. (Attach a copy of incident report if applicable)

[ ] Over exposure of the whole body to 5 rems or more
[ ] Over exposure of the whole body to 25 rems or more
[ ] Over exposure of the skin of the whole body to 30 rems or more
[ ] Over exposure of the skin of the whole body to 150 rems or more
[ ] Over exposure of the feet, ankles, hands or forearms to 75 rems or more
[ ] Over exposure of the feet, ankles, hands or forearms to 375 rems or more
[ ] Exposure of an individual to radiation in excess of any applicable limit set forth in the rules
[ ] Levels of radiation in an uncontrolled area in excess of 10 times any applicable limit set forth in the rules
Briefly describe circumstances of the incident: (Attach additional sheet if necessary)

CATEGORY OF STAFF INVOLVED IN THE INCIDENT (Check all that apply)

[ ] Radiologist  [ ] Radiological Technician  [ ] Other (Specify) __________________________

Immediate Corrective or Preventative Action Taken: (attach additional sheet if necessary)

________________________________________________________________________

________________________________________________________________________

Note: If the incident involved a death, was the medical examiner notified?  [ ] YES  [ ] NO  [ ] N/A
Was an autopsy requested?  [ ] YES  [ ] NO

Name and contact number of Medical Examiner ________________________________

Acknowledgement of Information Reported:

I attest that the information reported within this form is true and accurate and completed to the best of my knowledge.

Name of Person Completing Form  Title  Date Completed

Print Name

For Department Use Only

Received in S/A Date: ________________
Reviewed By: ________________________ Date: ________________
Reporting time frame met? ( ) Yes ( ) No
Action Required? ( ) Yes ( ) No
Self Report ID: ________________ Complaint #: ________________

This report is required as set forth in the X-ray Rules § 290-5-22-07 (2) and (4)