GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor **Frank Berry, Commissioner**

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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)