GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Healthcare Facility Regulation Division
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DRUG ABUSE AND TREATMENT AND EDUCATION PROGRAMS
AND
NARCOTIC TREATMENT PROGRAMS

REQUIRED SELF REPORTS TO THE DEPARTMENT FORM

FACILITY INFORMATION

Facility Name:_____
_
License #:_____ Address:_____

City:_____ State:_____ Zip Code:_____

Person Reporting Incident:_____ Title:_____

Phone Number:_____ Fax #:_____E-mail Address:_____

INCIDENT REPORTING INFORMATION (report within 24 hours)

Date:_____ Time _____ a.m. / p.m. Incident Occurred

Date:_____ Time _____ a.m. / p.m. Facility was aware that reportable incident may have Occurred

Patient Name: _____ Age:_____ Sex:_____ Date of Birth:_____

TYPE OF INCIDENT: Please check appropriate box

[ ] Death
[ ] Accident or injury requiring medical treatment and/or hospitalization
[ ] Emergency safety intervention resulting in injury of patient requiring medical treatment beyond first aid
[ ] Incident that resulted in any federal, state, or private legal action by or against the facility which affects any child or the conduct of the facility.

Briefly describe circumstances of the incident: (attach additional sheet if necessary)

Immediate Corrective or Safety/Prevention Action Taken:

_____
_____
_____
_____
_____
_____

Names of staff/patients involved or witnesses:

_____
_____

List of other persons/agencies notified of accident:

_____
_____

Acknowledgement of Information Reported:

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

Signature of Person Completing Form:_____Title:_____

Print Name:_____ Date Completed:_____

For Department Use Only

Date Received:_____ Date Reviewed:_____

Reviewed By:_____ Incident Report #_____