GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Healthcare Facility Regulation Division
Health Care Section
2 Peachtree Street, N.W. Suite 31-447
Atlanta, Georgia 30303
Tel: 404.657.5440 Fax: 404.657.8934

REQUIRED HOSPITAL SELF REPORTS - EVENTS / INCIDENTS

(Please Type or Print Form)

FACILITY INFORMATION

Name of Hospital: _____

Hospital Type: _____ **License #:** _____
See Chapter 290-9-7-.03(c)1

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Contact Person(s): _____ **Title:** _____

Phone Number of Contact: _____ **Fax #:** _____

Email Address: _____

Incident Information

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

Date _____ **Time** _____ **a.m./p.m.** **Hospital was Aware that Reportable Incident May have Occurred**

Date _____ **Time** _____ **a.m./p.m.** **Reported to HFRD Agency**

Type of Event / Incident: Please check appropriate boxes
The hospital shall make a report of the event within 24 hours or by the next regular business day from when the reportable event occurred or from when the hospital has reasonable cause to anticipate that the event is likely to occur. ***The following events/incidents are reportable if significant disruption of patient care has occurred or is expected to occur.***

[ ] A labor strike, walk-out, or sick-out
[ ] An external disaster or other community emergency situation
[ ] An interruption of services vital to the continued safe operation of the facility, such as telephone, electricity, gas, or water services

Anticipated effect on patient care services, including any need for relocation of patient:

_____

_____

_____

_____

_____

_____

Immediate plans by the hospital regarding patient management during the event:

_____

_____

_____

_____

_____

_____

Acknowledgement of Information Reported:

I certify that the information reported within this form is true, accurate, and complete to the best of my knowledge.

_____ _____ _____

Signature of Person Completing Form ***Title*** ***Date Completed***

_____

Print Name

For Department Use Only

Received in SA Date:_____

Reviewed By:_____

Date:_____

Reporting time frame of 24 hours/next business day met? ( ) Yes ( ) No

Action Required ( ) Yes ( ) No

Self Report ID #: _____ Complaint Number: _____

This report is required as set forth in the Hospital Rules §290-9-7-.07 (2) and must be submitted to the Department within twenty-four (24) hours or by the next regular business day from when the incident occurred, or from when the facility has reasonable cause to suspect a reportable incident §290-9-7-.07(2)(b)