RADFORD UNIVERSITY

Clinical Simulation Center

Adverse Occurrence Report

Original Date: April 2014 Review/Revision Date: May 2019

Approved: May 2019

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.