MARION EYE CENTER
& Optical

Patient/Visitor Injury/Incident Report

NAME_____Phone Number_____

STORE LOCATION WHERE INCIDENT TOOK PLACE_____

SUPERVISOR AT TIME INCIDENT HAPPENED_____

DATE OF INCIDENT_____TIME OF INCIDENT_____

WAS THE PERSON INJURED? ☐ YES   ☐ NO   ☐ UNKNOWN

    IF YES or UNKNOWN, DESCRIBE THE NATURE OF THE INJURY AND ANY BODY PARTS AFFECTED_____

_____

_____

_____

WAS MEDICAL ATTENTION REQUIRED IMMEDIATELY?   ☐ YES ☐ NO

    IF SO, DESCRIBE WHAT KIND AND WHERE IT TOOK PLACE:_____

_____

WAS MEDICAL ATTENTION SOUGHT 24 HOURS OR MORE AFTER INCIDENT?   ☐ YES   ☐ NO

    IF SO, REASON FOR DELAY:_____

    WHERE AND DIAGNOSIS:_____

    HOW LONG AFTER INCIDENT?_____

ACCOUNT OF INCIDENT:

WITNESS(ES):_____ _____ _____

SPECIFIC LOCATION ON SITE WHERE INCIDENT OCCURRED:_____

MACINERY OR EQUIPMENT INVOLVED AND NATURE OF INVOLVEMENT:_____

_____

_____

SEQUENCE OF EVENTS LEADING UP TO AND INCLUDING INCIDENT:_____

_____

_____

_____

INDIVIDUAL'S SIGNATURE_____DATE_____

INDIVIDUAL'S ADDRESS_____CITY_____ST_____ZIP CODE_____

STORE SUPERVISOR'S SIGNATURE_____DATE_____