ROXBOROUGH MEMORIAL HOSPITAL
SCHOOL OF NURSING

EVENT REPORT FORM

This form should be completed by the student and submitted to the Director of Recruitment, Admissions and Student Health Services within 24 hours via email after an incident occurs.

Student Name:____

Date of Event Report: __________________________Date of Event: ________________________

Location the Event occurred:____

Clinical Instructor:____

Person(s) involved in the Event: ____

Event Description:____

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Equipment used during the Event:____

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Initial Action(s), (i.e., flushing, HCP assessment, etc.): _________________________________

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Describe planned follow-up action(s) (i.e., HCP Follow-up, etc.): _______________________

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Signature of Student: _______________________________________ Date: ___________________

Student Address: ____

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Phone Number: ____