

**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: _____

Equipment used during the Event: _____

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

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

Signature of Student: _____ Date: _____

Student Address: _____

Phone Number: _____