RADFORD UNIVERSITY
Clinical Simulation Center

Adverse Occurrence Report

Original Date: April 2014 Reviewed: Annually
Last approved: May 2022

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.