KINGDOM OF SAUDI ARABIA
Ministry Of Education
KING ABDULAZIZ UNIVERSITY
FACULTY OF DENTISTRY
University Dental Hospital

المملكة العربية السعودية
وزارة التعليم
جامعة الملك عبدالعزيز
كلية طب الأسنان
مستشفى الأسنان الجامعي

Incident Reporting Form

Reported by: **Date of incident**: **Time:** am/pm

Department/Clinical session: **Supervisor's Name:**

Location of incident:
Building Number: **Floor:** ☐ Ground ☐ First ☐ Second

Severity ☐ Minor ☐ Moderate ☐ Near miss ☐ Sentinel
Type of Incidents:
☐ Incident involving health care worker ☐ Incident involving patient Incident involving other personnel

Classification of Incident:
☐ Verbal Abuse ☐ Physical ☐ Abuse Unsafe working environment ☐ Infection control violation
☐ Treatment error ☐ Sharp injury ☐ Others (Specify):

Describe type of incident and the immediate corrective action taken(attach additional sheet if required)**:**

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Incident witnessed: ☐ Yes ☐ No
Full Name of witness: **Contact number:**
Name of patient or any other party involved: **KAUDH file No.:**

Complete investigation report below, action taken and recommendations by the supervisor(attach additional sheet if required)**:**

Supervisor's Name: Position/Rank:

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Supervisor's signature: **Date:**

Complete investigation report below, action taken and recommendations by the head of department(attach additional sheet if required)**:**

Head of department:	**Department:**
Signature:	**Date:**