

# INCIDENT REPORT – SANTA CLARA COUNTY SENIOR NUTRITION PROGRAM

COMPLETE IMMEDIATELY FOR EVERY INCIDENT AND SEND TO SNP ASSIGNED DIETITIAN

Site:		City:	
Name of Person Involved (Last, First):		Male: <input type="checkbox"/> Female: <input type="checkbox"/>	Age:
Exact Location of Incident:		Date of Incident:	Time of Incident: AM PM
Property Involved: Yes <input type="checkbox"/> No <input type="checkbox"/>	Describe Property and Damage Involved:		
Equipment Involved: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Description of incident by person involved:			
Describe exactly what happened- why and/or how it happened. If there is an injury, give detailed information.			
Name, address, and phone number of witness(es):			
Was person involved seen by a physician? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date: Time: AM PM	Where?	
Physician's Name:			
Physician's Address and Phone Number:			
Physician's Statement:			
Date of Report:	Person Preparing Report: Title: _____ Signature: _____		
General Comments:			