Communicative Disorders Clinic
San Francisco State University

Incident Report Form

Date of incident: _____/____/______ Time of the incident: ________ AM/PM

Location of Incident: ___________________________________________________________

Individual involved is a: ( ) Client ( ) Faculty/Staff ( ) Visitor ( ) Other _________________

Name of Individual: _____________________________________________________________

Day Phone number: _______________ Evening Phone number: _______________

Briefly describe what happened:

Prepared by: ___________________________ Date: _______/_____/______

(Individual witnessing or hearing of occurrence)

Routed to ____________________________, supervisor for review/action Date: _________________

*********************************************************
FOR OFFICIAL USE ONLY-DO NOT COMPLETE THE FOLLOWING

Form received by: ___________________________ Date: ___/___/___

Supervisor’s comment:

Recommended actions:

______________________________________________________________

Route to Clinic Coordinator for review/comments: Date: __/___/

______________________________________________________________

Clinic Coordinator’s Signature: ___________________________ Date: __/___/___