



FAX THIS REPORT AND RETURN ORIGINAL TO:

Office of Health Facility Licensure & Certification  
Attention: Chronic Pain Management Program  
408 Leon Sullivan Way  
Charleston, WV 25301-1713  
P: (304) 558-0050  
F: (304) 558-2515

LOG NUMBER \_\_\_\_\_  
DATE \_\_\_\_\_

OFFICIAL USE ONLY

NOTE: If more than one patient is involved in the incident a separate reporting form is required for each patient. Additional sheets may be attached as needed, to report the information in its entirety.

**CLINIC INFORMATION**

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street Address

City

State

ZIP Code

Phone: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_

Name and Title of Person Completing Form: \_\_\_\_\_

**INVOLVED PARTIES**

Name of Patient : \_\_\_\_\_

Date of Admission  
to the clinic : \_\_\_\_\_

Was more than one patient involved?  Yes  No

Perpetrator (If any): \_\_\_\_\_

Name and Titles of All Staff Aware of the Event: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OUTSIDE MEDICAL ATTENTION**

Was outside medical attention required?  Yes  No

Name of Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Street Address

City

State

ZIP Code

