Texas State University **Attachment 1**
College of Health Professions
Adverse Event Report Form

Date of event:	Time of event:	TX State ID:
	Location of the event:	
Name of person completing this form: Name of person(s) involved in event:		
Addresses of persons involved in the event:	Phone Numbers of persons involved in the event:	
CHP Program:		
Describe the adverse event/incident/injury (Please be sure to state what you saw or what you heard and be sure to distinguish between what you actually saw and what you were told by others.):		
Any objects, equipment or substances involved?		
Did adverse event/incident/injury require physician/hospital visit?		
Name of Physician/hospital:	Address and phone:	
Signature or person completing report:	Date:	Received by:	Date:
Follow-up/Results:		
Supervisor signature:	Date:	

Return this report to the University Supervisor and the on-site supervisor within 24 hours of the adverse event.
Additional pages can be attached.