Nimkee Memorial Wellness Center

PATIENT INJURY / CONCERN & ACTION FORM

Date Received:

Date of Service:_____

Patient Name: _____

Phone #:_____

Patient Address:_____

DOB:_____

_____

Physician:_____

Contact Person:_____

TYPE OF INJURY / CONCERN

Lost / Damaged Item _____ Safety_____ Quality of Care_____ Billing_____ Other_____

Provider_____ (_____) Other Staff Member_____ (_____)
Name Name

DESCRIBE INJURY / CONCERN

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Signature: Person completing this section

INVESTIGATION

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_____	_____	_____	_____
Signature: Person completing this section	Date	Reviewed by	Date

RESOLUTION

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_____	_____	_____	_____
Signature: Person completing this section	Date	Reviewed by	Date

Further Action Needed: No____ Yes_____