OFFICE OF CLINICAL EXPERIENCES

FAX (252) 328-2361

Incident Report

Please submit this form to the Office of Clinical Experiences within 24 hours of the Incident.

NAME _____ _____ _____ _____
B

Last First Middle/Maiden ECU ID

_____ _____ _____

ECU E-Mail address Phone (Enter numbers only): Birthdate (MM/DD/YYYY)

ADDRESS

_____ _____ _____

Street City/State Zip

_____ _____

Instructor/University Supervisor: Date/Time of Incident (MM/DD/YY H:MM A/PM)

Location of Incident
Were there any witnesses? _____ _____

School Name District

◯ Yes ◯ No

If yes, please provide
name(s). _____

Please provide a specific description of the accident/incident:

By providing my full name and today's date below, I hereby certify that the information provided is true and accurate.

Full Name

Today's Date

Revised November 2015