NEW YORK INSTITUTE OF TECHNOLOGY

School of Health Professions

Adverse Clinical Incident Report

Please Return to the Office of Clinical Education

STUDENT NAME: ____CLASS of: ________
ADDRESS: ____

EMAIL: ______________________ PHONE #________________CELL #:
____

HOSPITAL/ SITE: ____

ROTATION: _________________DATE OF NEDDLE STICK: _____________________________

WHO WAS NOTIFIED?____

WAS BLOOD DRAWN FROM STUDENT? YES__ NO __

WAS BLOOD DRAWN FROM PATIENT? YES__ NO ___

DESCRIBE TREATMENT INITIATED, IF ANY:

____

____

____

COMMENTS:

____

____

____

***Student Signature*: _________________________________Date: _________________**

Note: Please attach a copy of any incident reports that you filed.