GSU/GT Center for Advanced Brain Imaging
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Incident Report Form

Date of Incident:	Time: *(AM/PM)*

Information of the Injured Person

Name:

Address:

Phone Number(s):

Date of Birth:	Male ◯ Female ◯

Who was injured? *(circle one)* Visitor Researcher Research Participant

Type of Injury:

Location of the Injury: *(e.g. corridor, computer lab, MRI suite)*	Did the injury or illness involve any of the following: *(check all that apply)* ☐ *Head* ☐ *Hand (R)(L)* ☐ *Foot (R)(L)* ☐ *Eye(R)(L)* ☐ *Arm (R)(L)* ☐ *Leg (R)(L)* ☐ *CPR* ☐ *AED* ☐ *Bleeding* ☐ *Fall* ☐ *Burn* ☐ *An electrical shock* ☐ *Poisoning*

Describe the accident:

What actions were taken?

Did the injury require physician or hospital visit? Yes ◯ No ◯

Signature of Person Completing Form:	Date:
Print your Name:	Witnesses:

Return this form to the Research Technologist within 24 hours of incident.