Dental Office Incident Report
An Incident Report Should Be Filed Within 48 Hours

Reported by: _________________________________ Date of Incident: ____________________ Date: ____________________

Dental Office: ____________________________________ Name of Supervising Dentist (print): __________________________

Office Address:  _________________________________________________________________________________________

City: ___________________________________________ Prov: ______________________ P.C.:_________________________

Type of Incident: __________________________________________________________________________________________

Witnessed: Yes ______   No ______  By: ______________________________   Title: _____________________________

NAME OF CLIENT AND/OR OTHERS INVOLVED: ______________________________________________________________


   Other (specify) ______________________________________________________________________

TYPE OF INCIDENT: (attach additional sheets as required)

Was the dentist notified:  Yes_____   No _____ Did the dentist examine the patient post incident:  Yes ____ No ____

(Describe briefly what happened: (attach additional sheets as required)

Type of Injury: __________________________________________________________________________________________

Suggested Treatment: _____________________________________________________________________________________

_______________________________________________________________________________________________________

Other Recommendations:  __________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

(Signature of Person Reporting Incident)               (Signature of Office Manager/Receptionist)
Supervisor's Investigation Report

Employee Name (print): ________________________________ Address: ____________________________________________
City: ___________________________ Postal Code: ______________ Phone: __________________________
Occupation: __________________________________________ Years of Experience: __________________________
Nature of Injury: __________________________________________________________________________________________
Injured Part of Body: _______________________________________________________________________________________ 
Signature of Witness 1: ___________________________ Signature of Witness 2: __________________________
Check as applicable:
Identify Incident:  □ First Aid  □ Medical Aid  □ Other
Type of Incident:  □ Near Miss  □ Dangerous Occurrence  □ Unusual Occurrence
Aggressive Behavior:  □ Physical  □ Verbal
Sharps:  □ Needle Sticks  □ Scalpels  □ While Suturing  □ Other
In the case of sharp injury; was Medical Health Officer notified: Yes: _______  No: ________
Describe clearly how the incident occurred:

What acts or failures to act and/or conditions contributed to this incident?

What action has or needs to be taken to prevent recurrence?

__________________________  ____________________________
Employee Signature  (Date)    Employer’s Signature   (Date)

FORM PROVIDED AN A COURTESY OF THE SASKATCHEWAN DENTAL ASSISTANTS’ ASSOCIATION