



**DELTA SOCIETY**<sup>®</sup>  
*The Human-Animal Health Connection*<sup>™</sup>

## PET PARTNERS<sup>®</sup> INCIDENT REPORT FORM

Date of Incident:	Time:
Place of Incident:	Contact Name:
Address:	City:
State/Zip:	Phone Number:
Reported By:	Phone Number:
Reported To:	Phone Number:

How did the incident happen? (Who, What, Where, When, Why, How)


Witness(es)	
Name:	Name:
Phone:	Phone:
Comments:	Comments:

Who was involved?	<input type="checkbox"/> Volunteer/Person	<input type="checkbox"/> Client
	<input type="checkbox"/> Animal	<input type="checkbox"/> Staff
Did incident occur during a visit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Volunteer's Name:		ID# (If Applicable):
Address:		City:
State:		Zip Code:
Phone:		Email:
Volunteer is a: (check all that apply)	<input type="checkbox"/> Pet Partner	<input type="checkbox"/> Pet Partner Instructor
	<input type="checkbox"/> Team Evaluator	<input type="checkbox"/> Other: _____
Animal's Name:	Species:	Breed:

Name of person(s) involved in incident:	
Did incident involve apparent injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Complete the following section <i>only</i> if an injury occurred.</b>	
Was first aid given?:	
Who administered first aid?	
Did the person(s) or animal(s) involved in the incident resume his/her/their activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please explain:	
Was further medical treatment required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did person need to consult with a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**RN or MD Evaluation (if available):**

Please describe injury:	
Will further medical treatment be required?	
_____	_____
RN or MD Signature	Date

_____ Name of Pet Partner Volunteer (Printed)	_____ Signature	_____ Date
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_____ Name of Person Involved in Incident (Printed)	_____ Signature	_____ Date
_____ Address of Person Involved in Incident	_____ Phone Number	

_____ Name of Witness #1 to Incident (Printed)	_____ Signature	_____ Date
_____ Name of Witness #2 to Incident (Printed)	_____ Signature	_____ Date

_____ Name of Facility Supervisor (Printed)	_____ Signature	_____ Date
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**Please return this form to:**

Delta Society® 875 124 <sup>th</sup> Ave. N.E. Suite 101 Bellevue, WA 98005	Questions? Phone: 425-226-7357 FAX: 425-235-1076
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For Delta Society Office Use Only	
Date Delta Society received report:	Date Incident Filed:
Action Taken:	
Delta Society Staff Signature/Date:	