

OKLAHOMA DEPARTMENT OF CORRECTIONS
REPORT OF INJURY OR UNUSUAL OCCURRENCE/ENCOUNTER

Facility		Name	ODOC #	Housing Assignment
Date of Occurrence	Time of Occurrence	Date and Time Reported To Health Services Unit	Place of Occurrence	

Occurrence/Encounter Involved:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Inmate on Inmate Assault | <input type="checkbox"/> Inmate on Staff Assault | <input type="checkbox"/> Sexual Assault | <input type="checkbox"/> Self-Mutilation |
| <input type="checkbox"/> Use of Force | <input type="checkbox"/> Tattooing | <input type="checkbox"/> Injection Drug Use | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Accidental | <input type="checkbox"/> Work Related | <input type="checkbox"/> Sports Related | <input type="checkbox"/> Needle Stick Injury |
| <input type="checkbox"/> Death | <input type="checkbox"/> Bloodborne Pathogen Exposure: <input type="checkbox"/> Staff <input type="checkbox"/> Inmate | | |

Other: _____

Occurrence/Encounter Involved:

- ☐ Other Inmate(s) ☐ Self Only ☐ Staff

Brief summary of the circumstances of the injury or unusual occurrence/encounter as provided by the inmate/staff member:

Witness(es):

Name _____	ODOC # _____	Name _____	ODOC # _____
Name _____	ODOC # _____	Name _____	ODOC # _____

Witness(es) Description:

Witness(es) Signature: _____ Date: _____

_____ Date: _____

_____ Date: _____

Employee Signature: _____ Date: _____

History of prior documented encounters? ☐ Yes ☐ No

Do you wish to be seen in Health Services? ☐ Yes ☐ No

Did you inform a correctional staff member? ☐ Yes ☐ No Date _____

 Signature of Person Completing Form Date _____