Safety Concern/Suggestion Report Form

To: ☐ Risk Management ☐ Safety Department

Date: _____

Method of Referral: ☐ Telephone ☐ Personal Contact

Employee ____ ☐ Anonymous
Visitor ____
Patient ____

☐ Hospital Employee
☐ Clinic Employee
☐ Caring Employee
☐ Apothecary Employee

☐ Quality of Care Concern ☐ Risk Concern ☐ Request for Information

Response Requested _____ Signature (not required) _____

Environment of Care Follow-up

Response Requested

Signature (not required)

This confidential documentation is prepared solely for Environment of Care Committee and its peer review function, including reduction of morbidity and mortality within the hospital. It should not be duplicated without authority form Environment of Care Committee or made available to anyone without the authority of Environment of Care Committee.