Medical Staff Conduct Event Report

Event Demographic Information			
Date of Report		Date/time of Reported Event:	Location of Event:
Name of Individual Reporting Event			
Medical Staff Member or Affiliate who is Subject of Reported Event			
Other Employees/Staff Involved		Patient(s) Involved (include MRNs)	
Name of Individual Completing Form	______________ ☐ Nursing Supervisor/Department Manager ☐ Member/Medical Affiliate of Medical Staff ☐ Chairman		

Summary of Event	
______________ Name of Nursing Supervisor, Department Manager or Member of Medical Staff Completing Form	______________ Date Report Filed

Involved Member Comments

Resolution (for use by Chief, Chair, and/or President/President-Elect MS only)

Signature of Physician Completing Form: ______________ Date: ______________

❑ Chief ❑ Chair ❑ President/President-Elect

CONFIDENTIAL: ***For Peer Review Only***

Return completed form to the Medical Staff Office

Rev. 5/2018