

Blue Ridge Area Health Education Center

A Program of the Institute for Innovation in Health and Human Services

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COMMUNITY HEALTH INTERPRETER SERVICE INCIDENT REPORT FORM

Interpreter Name:
Date (when the incident took place)Time:
Location:(Name of clinic, hospital, provider, etc.)
(Name of clinic, nospilal, provider, etc.)
Names(s) of Personnel Involved in the Incident:
Please describe with as much detail as possible what happened (include, as appropriate the patient's name, code number):