Day 5, Exercise 7 – Medical Event Report

1	**Date of Report:**
2	**Name of Person Reporting Event:**
3	**Date of Event:**
4	**Facility Name:**
5	**Facility Address:**
6	**Location of Accelerator (room number):**
8	**Correspondence Address/Phone Number:**
9	**Radiation Safety Officer:**
10	**Medical Physicist:**
11	**Responsible Physician:**

12	**Accelerator Description:** **Make:** **Model:** **Serial Number:** **Manufacture Year:** **Remanufactured Year:** **On Board Imaging CT: Yes ☐ No ☐**	**11**	**Maximum Accelerator Energy Data:** **Electrons** _____ **MeV** **Photons** _____ **MV** **FFF Photons** _____ **MV** **Other Particles** _____ **Other Particle Energy** _____ **MeV**

12 Describe use of the medical accelerator during the incident:

- ☐ **Quality Assurance Testing**
- ☐ **IORT**
- ☐ **IMRT**
- ☐ **Arc Therapy**
- ☐ **Stereotactic (SRS, SRT, SBRT)**
- ☐ **Other (explain)**_____

13 Brief Description of the Event:

a) When and how did you become aware of the event?
b) What details of the event classified the event as reportable (i.e. what limits were exceeded)?
c) Why did the event occur?
d) The effect, if any, on the individual(s) who received the administration

14 Corrective Actions: What actions, if any, have been taken or are planned to prevent recurrence?

15 Notifications:

a) Did you notify the affected individual of the event, if not, why not?
b) Did you notify the referring physician, if not, why not?