

ADVERSE EVENTS FORM**To be completed by individual noticing the adverse event**

| | |
|------------------------|--------|
| Surname: | |
| Forename: | Title: |
| Work telephone number: | |
| Job Title: | |

Adverse event/ Incident Details

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|---|--------------------------|
| Event/ Incident Date: | Time of Event/ Incident: |
| Site (Name of Trust / Clinic /University) | |
| Location (Please give specific details): | |

Description of Adverse Event / Incident: *Please give specific detail*

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| Have recommendations been made by line management to prevent a similar incident recurring | Yes | No |
|---|-----|----|

Signature of person initiating Adverse Event log:**Date:**

ADVERSE EVENTS FORM**TO BE COMPLETED BY EDU MANAGER**

Please record details of action taken:

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Please tick appropriate box and enter details:

| | | |
|---|--|-----------|
| Has the School of Life Sciences Quality Officer been notified? | Yes Name of QO: | |
| If appropriate, has the University of XXXXXXXX Health and Safety Officer been notified? | Yes Name of Safety Officer: | No |
| If appropriate, has the relevant Trust/Clinic been notified? | Yes Name of Trust : | No |
| Name of EDU MANAGER completing the Adverse Event Form: | | |
| Signature: | Date: | |

On completion:

- **Original to be kept in the EDU**
- **Copy to Person initiating the Adverse Event log**
- **Copy to SoLS QO**