

Form for Reporting a Patient Safety Concern by Mail

Thank you for taking the time to share your patient safety concern or event regarding a Joint Commission accredited or certified organization. The Joint Commission takes any information about one of our accredited or certified organizations seriously.

Please complete the following to submit a safety concern or event regarding a Joint Commission accredited or certified organization. (Note: if you cannot locate an organization within the dropdown menu, the organization may not be accredited or certified by The Joint Commission.)

Please read the following The Joint Commission Disclaimer before proceeding.

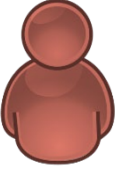
Disclaimer:

1. The Joint Commission does not evaluate the care of an individual, or whether that care was appropriate. Instead, our evaluation focuses on processes that are required within our standards.
2. Issues related to billing, insurance or labor disputes are not within The Joint Commission Standards. We encourage you to contact the organization directly for resolution.
3. If confidentiality is not waived, we may still act on your reported safety concerns following our established processes for anonymous reporting. Anonymous reporting is no promise of confidentiality since the organization could independently investigate and become aware of your identity.
4. Please be aware that in line with our Public Information Policy, we cannot provide you with the organization's response should an inquiry be pursued.

I have read and understand The Joint Commission Disclaimer.

 Location (where the concern or event occurred)	Organization Name (required)		
	Organization Street Address (required)		
	City (required)	State (required)	Zip Code (required)

(Continue to next section)

 Your Information	Please provide your information below so The Joint Commission can contact you if there is a need for additional information regarding your safety concern or event, as well as to provide you with updates regarding the status of your submitted safety concern or event. Providing an email address is required to enable further review of your reported concern. Your name/identity as the source will be kept confidential unless you allow us to share your name with the organization (see page 2 and disclaimer).		
	<i>First Name</i>	<i>Middle Init</i>	<i>Last Name</i>
	<i>Email (required)</i>		
	<i>Street Address</i>		
	<i>City</i>	<i>State</i>	<i>Zip Code</i>

 Incident Information	What is the nature of the patient safety incident you are reporting? Physical or mental harm that occurred. Please select which most accurately describes the harm experienced. Death occurred Permanent or long-term harm was experienced Further treatment or other procedure was needed Extra observation or minor treatment was needed Psychological harm occurred Other harm occurred Unsafe practices or conditions occurred, which could have resulted in harm		
	How often have the events you are reporting, or similar type events, occurred before? Never Rarely Sometimes All the time I don't know		
	Are these events ongoing? Yes No I don't know		

(Continue to next section)

	Date safety event occurred (required)					
	<i>Month:</i>		<i>Day:</i>		<i>Year:</i>	
	Incident Narrative: Please use the open space below to provide a description of the safety event, including the patient's name, if known. <u>Note: By policy, The Joint Commission cannot accept copies of medical records, photos or billing invoices and other related personal information. These documents will be shredded upon receipt.</u>					
Description of Concern or Event						
<i>Type or Write Narrative Here:</i>						

(Continue to next section)

 Description of Concern or Event	Are you aware of any actions that were taken to prevent further events? Yes (please describe below) No I'm not sure Have you reported this information elsewhere? Yes, directly to the healthcare organization Yes, to the State Department of Health Yes, to another agency No, I have not reported elsewhere		
 Confidentiality Waiver	The Joint Commission is here to help organizations improve. We will use your report to better understand systems of care and guide improvement. We will review your report and determine how best to evaluate your concerns. This could include contacting the organization about your concern. Should we decide to contact the organization about your concern, please confirm whether you give The Joint Commission permission to: ➤ <i>Release your name as the source of this concern and share a copy of the information you have sent to The Joint Commission with the organization.</i> Please select one (required) Yes, I give The Joint Commission permission to share my name as the source of information and share a copy of the information I have sent with the organization. ➤ <i>If yes, please provide your name if it is not included in previous section:</i> <table border="1" data-bbox="487 1291 1461 1375"> <tr> <td>First Name:</td> <td>Last Name:</td> </tr> </table> No, The Joint Commission may not share my name as source and a copy of the information may not be shared with the organization. *Please be advised • Permission to share may not result in an inquiry, but it will enable sharing your name as source and a copy of the information should The Joint Commission decide to write the organization about your concern. • If confidentiality is not waived, we may still act on your reported safety concerns following our established processes for anonymous reporting. Anonymous reporting is no promise of confidentiality since the organization could independently investigate and become aware of your identity. Thank you for bringing your concerns to our attention and helping us with our mission of continuously improving healthcare.	First Name:	Last Name:
First Name:	Last Name:		