



Creating  
a State  
of Health

**PROTECTIVE  
HEALTH  
SERVICES**

Oklahoma State Department of Health  
Consumer Health Service  
PO Box 268815  
OKC, OK 73126-8815  
Telephone: (405) 271-5243  
FAX: (405) 271-5286

**PUBLIC BATHING PLACE - INCIDENT REPORT FORM**

Please check the type of incident (mark all that apply):  Injury  Contamination

In the event of a **DROWNING** or **HOSPITALIZATION**, call your local county health department or Consumer Health **IMMEDIATELY** after the incident is handled with local medical authorities.  
Outside of business hours M-F / 8-5, leave a message with local health (if available) or Consumer Health (405-271-5243).

**INJURY INCIDENT**

Injury Type:  Drowning Resulting in Death  Recovered Drowning  Hospitalization  Other: \_\_\_\_\_

Name of Person Injured: \_\_\_\_\_ Age: \_\_\_\_\_

Was the Injured Person a:  Bather  Observer

Parent/Guardian Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_ &/or Email: \_\_\_\_\_

Address: \_\_\_\_\_

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Actions Taken (mark all that apply):

Contacted 911 or other ER #: \_\_\_\_\_ Who Called: \_\_\_\_\_ Time of Call: \_\_\_\_\_

CPR Performed; Who Performed: \_\_\_\_\_ Time Started: \_\_\_\_\_

Time of Emergency Medical Services Arrival: \_\_\_\_\_ or  Patient Refused Assistance

**Attach** a Brief Summary of Incident (person(s) on duty/location/other witnesses and contact information; type of injury/reasons injury may have resulted).

**CONTAMINATION INCIDENT**

Contamination Type (mark all that apply):  Fecal-Solid  Fecal-Watery  Vomit  Blood  Other: \_\_\_\_\_

Area(s) Contaminated (mark all that apply):  Water\*  Deck  Bathhouse  Other: \_\_\_\_\_

\*If separate pump systems, list pool contaminated: \_\_\_\_\_

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Actions Taken (mark all that apply):

Closed Facility: Time Closed: \_\_\_\_\_ Sanitizer levels at time of incident: \_\_\_\_\_

Pool/Spa Treated:  Chemical (type/amount): \_\_\_\_\_  Filter Cleaned

Area Cleaned  # of Complete Turnovers before Opening: # \_\_\_\_\_

Measurements: pH: \_\_\_\_\_ CYA: \_\_\_\_\_ Temp: \_\_\_\_\_ Chlorine (ppm): \_\_\_\_\_

Water Drained  Facility Reopened: Time: \_\_\_\_\_ Date: \_\_\_\_\_

**Attach** a Brief Summary of Incident (person(s) on duty/location/other witnesses and contact information; etc.).

Certified Pool Operator Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

CPO Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Mail a copy of final report to local county health department within seven (7) days of incident.*