Provider Name ___________________________________

Incident Report Form

	UI Log Number:
Individual's Name	
Address	City
Reporter: Agency / Family / Other	
Date of Incident	Time of Incident ☐ AM ☐ PM
Discovery Date of Incident	Time of Discovery ☐ AM ☐ PM
Location of Incident (Ex - home in kitchen, parking lot, lunchroom at work)	
Description of Incident (Who, What, Where, When)	
Injury (Describe Type / Location / Dimensions / Color) No injury ☐	
Immediate Action to Ensure Health & Welfare of Individuals (Give Specific Detail – Not continue to monitor or notify supervisor)	
Name of PPI(s) (others involved)	Relationship to Individual
Witnesses to Incident	Others Involved

Type of Notifications	***Name / Title***	***Date / Time / Method***
Other is to include Licensed / Certified Provider; Staff / Family responsible for care; Law Enforcement; Children's Svcs / Adult Protective Svcs; Administrator (Required for ICF); Support Broker (if applicable); Investigative Agent		
Guardian / Advocate		
SSA / CB		
Other		
Other		
Other		

Causes and Contributing Factors:

Preventive Measures:

Signature of Person Reporting the Incident	Printed Name	Time:	Date:
/		___________ a.m./p.m.	____/_____/_____

Unusual Incident Report Sent to Community Services Department: Yes ☐ No ☐

Additional Information / Administrative Follow-Up

A. Further Medical Follow-Up:

B. Administrative Action:

Administrator Signatures:

Administrator: ____ Title: ___________________________ Date: ______________

Administrator: ____ Title: ___________________________ Date: ______________

4/29/15