MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

# INCIDENT REPORT

| | |
|---|---|
| REPORT DATE | TIME |
| AGENCY NAME | |
| WORK AND LIVING UNIT NAME | |

RECIPIENT NAME

CASE NO.

AGE/BIRTHDATE

SEX

PRINT OR USE ADDRESSOGRAPH PLATE

| WHEN DID YOU DISCOVER INCIDENT (Date & Time) ☐ AM ☐ PM | WHEN DID IT HAPPEN (Date & Time) ☐ AM ☐ PM | WHERE DID INCIDENT HAPPEN (Building, Location) ☐ AM ☐ PM |
|---|---|---|

| RECIPIENT(S) INVOLVED | OTHER RECIPIENT(S) PRESENT |
|---|---|

EMPLOYEE(S) INVOLVED AND/OR PRESENT

EXPLAIN WHAT HAPPENED

ACTION TAKEN BY STAFF

| PHYSICAL INJURY APPARENT? ☐ YES ☐ NO | REPORTING PERSON'S SIGNATURE & TITLE | DATE |
|---|---|---|

IF INJURY, DESCRIPTION OF INJURY BY PHYSICIAN OR R.N.

DESCRIPTION OF TREATMENT OR CARE GIVEN

| DATE & TIME CARE GIVEN ☐ AM ☐ PM | EXTENT OF INJURY AT THIS TIME ☐ SERIOUS ☐ NON-SERIOUS | PHYSICIAN'S OR R.N. SIGNATURE | DATE |
|---|---|---|---|
| IF SERIOUS INJURY: DATE & TIME DIRECTOR OR DESIGNEE NOTIFIED ☐ AM ☐ PM | IF SERIOUS INJURY: DATE & TIME RIGHTS ADVISOR NOTIFIED ☐ AM ☐ PM | PHYSICIAN'S OR R.N. SIGNATURE | DATE |

DESIGNATED SUPERVISOR (State program or administrative action to remedy and/or prevent reoccurrence of incident, including disciplinary action)

| NAME OF EMPLOYEE ASSIGNED TO RECIPIENT AT TIME OF INCIDENT | DESIGNATED SUPERVISOR'S SIGNATURE |
|---|---|

WITHIN 24 HOURS, DISTRIBUTE: WHITE COPY – Director (Return to recipient records)
YELLOW – Rights Advisor
PINK – Agency

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