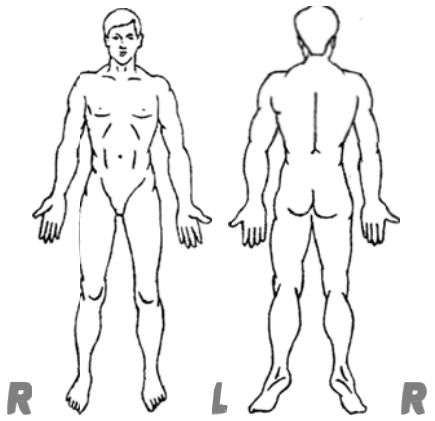
Provider Name & Address:		
Individual's Name:		DOB:
Address:		City/County:
Date of Incident: Time of Incident:		
Location of Incident (home in bathroom, at the mall, lunchroom at work):		
Description of Incident:		
Injury:		
Immediate Action to Ensure Health & Welfare of Individuals:		
Name of PPI(s):	Relationship to Individual:	
Witnesses to Incident:	Others Involved:	
Type of Notification	Name/Title	Date/Time
Guardian / Advocate		
SSA (required for Independent Providers		
Senior Management (For MUIs involving misappropriation, neglect, physical abuse , or sexual abuse only)		
Licensed or Certified Provider		
Staff or Family living at the Individual's home & responsible for the individual's care.		
LE (Name, Badge Number, Jurisdiction, and contact information required for Law Enforcement		
CPSA (Name and contact information required for Children Services)		
County Board		

Additional Information/ Further Medical Follow up :		
Administrative Action:		
Signature:	Title:	Date:
Printed Name		

Body Part Injured:
☐ Head or Face
☐ Mouth / Teeth
☐ Hands / Arms
☐ Feet / Legs
☐ Neck or Chest
☐ Abdomen
☐ Back / Buttocks
☐ Genitals
☐ Other _



Causes and Contributing Factors:		
Preventative Measures:		
Administrator:	Title:	Date:
Printed Name		