Greene County Board Of Developmental Disabilities
Unusual Incident Report Form

Provider Name:_____
Contact Information: _____

Person filling out report if different from above: _____

Individual's Name:	DOB:
Address:	City/County:

Date of Incident: Time of Incident: AM/PM

Location of Incident (home in bathroom, at the mall, lunchroom at work):

Description of Incident (Who, What, Where, When):

Immediate Action taken to Ensure Health & Welfare of Individuals:

Witnesses to Incident:	Others Involved:
	PPI (If Applicable):

Type of Notification	Name/Title	Date/Time
Guardian / Advocate		
SSA (required for Independent Providers)		
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		
Administrator (Required for ICF)		
Support Broker (If applicable)		

Injury Location: Check all the apply

__ Head or Face
__ Mouth / Teeth
__ Hands / Arms
__ Feet / Legs
__ Other _____
__ Neck or Chest
__ Abdomen
__ Back / Buttocks
__ Genitals

Injury Type:

Scratch ___ Red Mark ___
Burn ____ (indicate the degree of the burn)
Laceration ___ Other ____ (list below)
Bite ___
Bruise ___

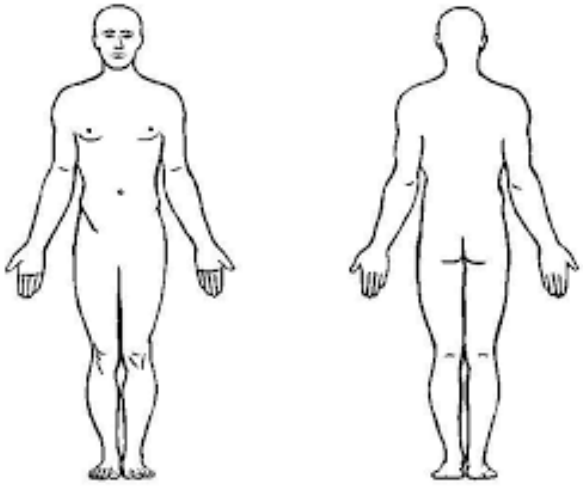
Description of Injury

_____

First aid/Medical Treatment completed:

_____
_____

Indicate location of Injury on the diagram below



Follow up:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Preventive Measures:

_____
_____
_____
_____
_____
_____

Reporting Person Signature: _____ Date: _____
ETS Signature (If Applicable) _____ Date: _____
Nurse Signature (If Applicable): _____ Date: _____
Supervisory /Administrator Signature (If Applicable) _____ Date: _____