Greene County Board Of Developmental Disabilities
Unusual Incident Report Form

Provider Name**:**
Contact Information:
Person filling out report if different from above:

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

Date of Incident: Time of Incident: AM/PM

Type of Incident:

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:

Cause and Contributing Factors (How/why the incident occurred):

Witnesses to Incident:	PPI (Primary Person of Interest):

Type of Notification	Name/Title	Date/Time
Guardian / Advocate		
Service and Support Administrator		
Licensed or Certified Provider		
Staff or Family living at the Individual's home & responsible for the individual's care.		
Law Enforcement (include Agency, Officer name/badge number, contact information)		
Child Protective Services (include name and contact information)		
County Board/MUI (report@greenedd.org)		
Administrator (ICF's only)		

Injury Location: Check all the apply

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

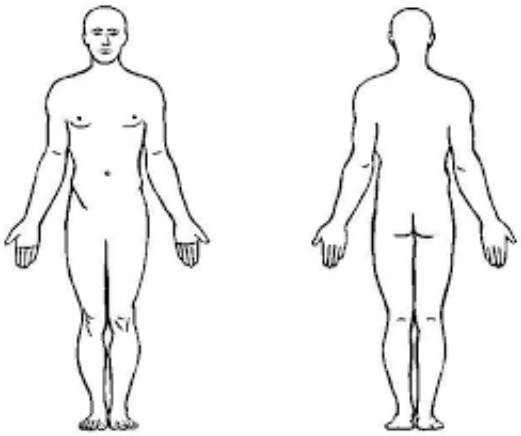
Injury Type:

- ☐ Scratch
- ☐ Burn
- ☐ Laceration
- ☐ Bite
- ☐ Bruise
- ☐ Red Mark
- ☐ Other (list below)

Description of Injury:

First aid/Medical Treatment completed:

Indicate location of Injury on the diagram below: (Use PDF highlighter to mark areas of injury location)



Follow up:

Preventive Measures:

Reporting Person Signature: _____ Date: _____

Manager Signature (If Applicable) _____ Date: _____

Nurse Signature (If Applicable): _____ Date: _____

Supervisory /Administrator Signature (If Applicable) _____ Date: _____