

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH INCIDENT REPORT

NAMEPLATE
INFORMATION ONLY

AGENCY INFORMATION			
Agency Name		Unit Name	
RECIPIENT INFORMATION			
Recipient Name	<input type="checkbox"/> Male	Case Number	
	<input type="checkbox"/> Female		
	Age	DOB	

INCIDENT INFORMATION		
When did you discover incident? (date and time) <input type="checkbox"/> AM <input type="checkbox"/> PM	When did incident happen? (date and time) <input type="checkbox"/> AM <input type="checkbox"/> PM	Where did incident happen?

Other Employees Involved and/or Present:

Recipient(s) involved: _____ Other recipient(s) present: _____

Explain what happened:

Action taken by staff:

Reporting Person's Signature _____ Date and Time of Report: AM PM

THIS SECTION MUST BE COMPLETED BY PHYSICIAN OR R.N. WHEN PHYSICAL INJURY TO THE RECIPIENT IS APPARENT

Description of injury:

Description of treatment or care given:

Date and time care given: AM PM Extent of injury at time care given: **SERIOUS*** **NON-SERIOUS** Physician/R.N Signature _____ Date _____

***Serious physical harm means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.**

REPORTING INFORMATION

If serious injury Director/Designee Notified: (date/time) AM PM If serious injury Rights Advisor Notified: (date/time) AM PM Notification made by (print name): _____

TO BE COMPLETED BY DESIGNATED SUPERVISOR

1. Name of employee assigned to recipient at time of incident : _____
 2. Indicate program or administrative action taken, including disciplinary action, to remedy and/or prevent recurrence of incident:

Designated Supervisor Signature _____ Date _____