

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH INCIDENT REPORT

NAMEPLATE
INFORMATION ONLY

AGENCY INFORMATION

Agency Name	Unit Name
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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?
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Other Employees Involved and/or Present:

Recipient(s) involved:	Other recipient(s) present:
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Explain what happened:

Action taken by staff:

Reporting Person's Signature	Date and Time of Report: <input type="checkbox"/> AM <input type="checkbox"/> PM
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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: <input type="checkbox"/> AM <input type="checkbox"/> PM	Extent of injury at time care given: <input type="checkbox"/> SERIOUS* <input type="checkbox"/> NON-SERIOUS	Physician/R.N Signature	Date
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***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) <input type="checkbox"/> AM <input type="checkbox"/> PM	If serious injury Rights Advisor Notified: (date/time) <input type="checkbox"/> AM <input type="checkbox"/> PM	Notification made by (print name):
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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
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