INCIDENT REPORT

Date:

Employee Name:

Consumer Name:

MCI NUMBER:

Date Of Birth:

**INCIDENT DETAILS**

 Date: Time:

 Location:

Was Law Enforcement contacted? YES [ ]  NO [ ]

Were guardian/caregivers contacted? YES [ ]  NO [ ]

Was medical assistance required? YES [ ]  NO [ ]

Description of incident and actions taken:

|  |
| --- |
|  |

By signing this document, you acknowledge that you have read and understood the information contained herein.

|  |
| --- |
| Employee Signature:  |

Date: