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: