MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

INCIDENT REPORT

REPORT DATE	TIME	RECIPIENT NAME
AGENCY NAME		CASE NO.
WORK AND LIVING UNIT NAME		AGE / BIRTHDATE
		SEX
WHEN DID YOU DISCOVER INCIDENT (Date & Time) ☐ **AM** ☐ **PM**	WHEN DID IT HAPPEN (Date & Time) ☐ AM ☐ PM	WHERE DID INCIDENT HAPPEN (Building, Location)

RECIPIENTS(S) INVOLVED

OTHER RECIPIENT (S) PRESENT

EMPLOYEE(S) INVOLVED AND/OR PRESENT

EXPLAIN WHAT HAPPENED

ACTION TAKEN BY STAFF

PHYSICAL INJURY APPARENT? ☐ **YES** ☐ **NO**	REPORTING PERSON'S SIGNATURE — DATE

IF INJURY, DESCRIPTION OF INJURY BY PHYSCIAN OR R.N.

DESCRIPTION OF TREATMENT OR CARE GIVEN

DATE & TIME CARE GIVEN ☐ **AM** ☐ **PM**	EXTENT OF INURY AT THIS TIME ☐ **SERIOUS** ☐ **NON-SERIOUS**	PHYSICIANS'S OR R.N. SIGNATURE — DATE
IF SERIOUS INJURY: DATE & TIME DIRECTOR OR DESIGNEE NOTIFIED ☐ **AM** ☐ **PM**	IF SERIOUS INJURY: DATE & TIME RIGHTS ADVISOR NOTIFIED ☐ **AM** ☐ **PM**	PHYSICIANS'S OR R.N. SIGNATURE — DATE

DESIGNATED SUPERVISOR (State program or administrative action to remedy and/or prevent reoccurrence of incident, including disciplinary action)

NAME OF EMPLOYEE ASSIGNED TO RECIPIENT AT TIME OF INCIDENT	DESIGNATED SUPERVISOR'S SIGNATURE

WITHIN 24 HOURS, DISTRIBUTE: PHOTO COPY
- Director (Return to recipient records)
- Rights Advisor
- Agency

DCH-0044(E) (1/01) (W) Replaced DMH-2550