



INCIDENT REPORT

Individual's Full Name: _____ DOB: _____
Address: _____ City/Zip: _____

Reported by: _____ SSA: _____
Incident Date: _____ Incident Time: _____ AM PM
Discovered On: _____ Discovery Time: _____ AM PM
Reported On: _____ Reported Time: _____ AM PM

Location of Incident: _____
Incident Provider: _____
Residential Provider: _____

Summary of Specific Incident Details (that answers the questions, "Who?, What?, When?, and Where?"):

Immediate Actions taken to ensure Health & Welfare of all Impacted Individual(s):

Cause and Contributing Factors:



Injuries:

- Location: Head/Face Chest/Neck Back
 Arm/Hands Leg/Feet Buttocks
 Other (list in detail)

- Cause: Known Unknown

Details of injury/Medical follow up:

[Empty text box for injury details]

Notifications:	Name	Date	Time
<input type="checkbox"/> Supervisor			
<input type="checkbox"/> MUI Reporting Line (937)296-1235 for all reportable MUIs • Email associated Incident Report to: mui@mcbdds.org by 3pm next day			
<input type="checkbox"/> SSA (Via phone call or Email SSA directly completed Incident Report) *****All UI Level Incident Reports go DIRECTLY to SSA*****			
<input type="checkbox"/> Law Enforcement - Jurisdiction:			
<input type="checkbox"/> Montgomery County Children's Services (937) 224-5437 phone - (937) 277-1127 fax			
<input type="checkbox"/> Provider(s)			
<input type="checkbox"/> Guardian/Family Member			
<input type="checkbox"/> Other - Title:			
<input type="checkbox"/> Other - Title:			

Others Involved:	Name	Title
<input type="checkbox"/> Alleged PPI		
<input type="checkbox"/> Witness		
<input type="checkbox"/> Witness		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

Preventative Measures:

[Empty text box for preventative measures]

Name & Title of person completing this Incident Report

Date