MICHIGAN DEPARTMENT OF COMMUNITY HEALTH **INCIDENT REPORT**

AGENCY INFORMATION		
Agency Name		Unit Name
RECIPIENT INFORMATION		
Recipient Name	☐ Male ☐ Female	Case Number
	Age	DOB

NAMEPLATE
INFORMATION ONLY

INCIDENT INFORMATION		
When did you discover incident? (date and time) ☐AM ☐PM	When did incident happen? (date and time) ☐AM ☐PM	Where did incident happen?
Other Employees Involved and/or Present:		
Recipient(s) involved:	Other recipient(s) present:	
Explain what happened:		
Action taken by staff:		
Reporting Person's Signature	Date and Time of Report: ☐ AM ☐ PM	

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: ☐AM ☐PM	Extent of injury at time care given: ☐ **SERIOUS*** ☐ **NON-SERIOUS**	Physician/R.N Signature Date

***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) ☐AM ☐PM	If serious injury Rights Advisor Notified: (date/time) ☐AM ☐PM	Notification made by (print name):

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