**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH INCIDENT REPORT**

|  |  |  |  |  |  |  |  |  |  |  |
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| **AGENCY INFORMATION** | | | | | | | | | | |
| Agency Name | | | | | | | Unit Name    NAMEPLATE  INFORMATION ONLY | | | |
| **RECIPIENT INFORMATION** | | | | | | | | | | |
| Recipient Name | | | | Male  Female | | | Case Number | | | |
| Age | | | DOB | | | |
| **INCIDENT INFORMATION** | | | | | | | | | | | | | | | | |
| When did you discover incident? (date and time) | | | | | When did incident happen? (date and time) | | | | | | | | Where did incident happen? | | | |
|  | | AM  PM | | |  | | | | AM PM | | | |
| 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) | | | | | | If serious injury Rights Advisor Notified: (date/time) | | | | | | | | Notification made by (print name): | | |
|  | | | AM PM | | |  | | | | AM PM | | | |
| **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 | | | | |
| DCH-0044 (W) 05/08 | DISTRIBUTION: WITHIN 24 HOURS 1.SEND ORIGINAL TO DIRECTOR 2. MAKE COPIES AND SEND TO: ORR & AGENCY | | | | | | | | | | | | | | | |