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| Provider Name & Address:  |
|  UI/MUI Report  |
|  Individual’s Name:  |  DOB:  |
|  Address:  |  City/County:  |
|   Date of Incident: Time of Incident: AM/PM  |
| Location of Incident (home in bathroom, at the mall, lunchroom at work):  |
| Description of Incident (Who, What, Where, When):  |
| Injury – Describe Type & Location:  |
| Immediate Action to Ensure Health & Welfare of Individuals:  |
| Name of PPI(s):  | Relationship to Individual:  |
| Witnesses to Incident:  | Others Involved:  |
| Type of Notification  |  Name/Title  |  Date/Time  |
| Guardian / Advocate  |   |   |
| SSA (required for Independent Providers)  |   |   |
| Licensed or Certified Provider  |   |   |
| Staff or Family living at the Individual’s home & responsible for the individual’s care.  |   |   |
|  LE (Name, Badge Number, Jurisdiction, and contact information required for Law Enforcement  |   |   |
|  Enforcement) CPSA (Name and contact information required for Children Services)  |   |   |
| County Board  |   |   |
| Administrator (Required for ICF)  |   |   |
| Additional Information/or Administrative Follow-Up: A. Further Medical Follow-up:  |  |  |  |  |  |
| B. Administrative Action:  |  |  |  |  |  |
| Signature:  | Title:  |   |   |   |  Date:  |

Causes and Contributing Factors:

Preventive measures: (For Provider’s internal use)

 Administrator Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_