|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_