|  |  |  |
| --- | --- | --- |
| Date of Incident: | | Time of Incident: AM/PM |
| Participant Name: | | Location of Incident: |
| Supervisor Notified:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Type of Incident**  \_\_\_\_ Injury:  \_\_\_\_ Participant \_\_\_Staff \_\_\_Visitor  \_\_\_\_ Damage:  \_\_\_\_ DeRiche Property \_\_\_\_ Personal Property  \_\_\_\_ Vehicle \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_ Infectious/Contagious Disease | **Classification of Incident (check any that apply):**  \_\_\_\_SIB \_\_\_\_\_Attention Seeking \_\_\_\_Security \_\_\_\_\_Other    \_\_\_\_\_Minor \_\_\_\_\_ Mild \_\_\_\_\_\_ Moderate \_\_\_\_\_Major | |
| **Location of Injury to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Mark on the figures the general area of any cuts, scratches, marks or bruises possibly relating to the incident/accident. | |
| \_\_\_\_ Medication Issue:  \_\_\_\_ error  \_\_\_\_adverse drug reaction, food/drug interaction  \_\_\_\_Property Loss  \_\_\_ Participant absence  \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |
| Other Person(s) Involved Participant, Staff, Visitor, please use first name or initials only: | | |
|  |  | |
|  |  | |
|  |  | |

**DeRiche Agency, Inc.**

**Internal Incident Report**

Report must be completed by employee within 24 hours of incident. If incident involves more than one participant, fill out separate report for each.

|  |  |
| --- | --- |
|  | A. Description of Incident |
| Was anyone injured? Was first aid needed? Who? Describe. |  |
|  |  |
| What happened before the incident took place? |  |
|  |  |
| What happened during the incident? |  |
|  |  |
| What occurred right after the incident? |  |
|  |  |
| Why did the incident occur? |  |
|  |  |
|  |  |
| What did you do? |  |

Name of person completing this Incident/Accident form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

# B. Review: Recommendations for Follow-up

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Person Reviewing Report:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Signature/Title Date