ATTACHMENT B

State Electronic Incident Report Form

Agency Name: ( )
Program: ( )

Date of Incident: 1/00/ 2011
Time of Incident: 6:00Hr.00 Min.
Duration of Incident: 1:00 Hr.00 Min.

*Subject of Incident: ( )

Subject Name: _____ _____
Last First

ONH Yes

Subject DOB: 1/00/1900
CT # / Staff #: /

Reportable Incident: ( )
Detail Type: ( )

Seclusion/Restraint: ( ) Is this intervention part of an individualized support plan: ( )

If Chemical, drug used: Is this intervention part of an individualized support plan:Yes

Date Subject last had contact with the Agency: ( ) or1/00/ 2009
Incident Location: ( )

Describe the events leading up to the incident.

Describe the incident –include the persons present.

Did injury to anyone result: Yes Describe, if "yes".

Describe the staff actions taken during the incident.

Describe the Subject's response to the staff actions taken.

Describe any follow-up with subject of incident including plans for further review.

Notifications	Name	Date	Time
QDDP:		1/00/ 2011	1:00 Hr.00 Min.
Supervisor:		1/00/ 2011	1:00 Hr.00 Min.
Program Manager:		1/00/ 2011	1:00 Hr.00 Min.
Director:		1/00/ 2011	1:00 Hr.00 Min.
Guardian:Public		1/00/ 2011	1:00 Hr.00 Min.
APS:		1/00/ 2011	1:00 Hr.00 Min.
DMH:		1/00/ 2011	1:00 Hr.00 Min.
DCF:		1/00/ 2011	1:00 Hr.00 Min.
DDAS:		1/00/ 2011	1:00 Hr.00 Min.
Police:		1/00/ 2011	1:00 Hr.00 Min.
Medical Provider:		1/00/ 2011	1:00 Hr.00 Min.
Other:		1/00/ 2011	1:00 Hr.00 Min.
Other:		1/00/ 2011	1:00 Hr.00 Min.
Other		1/00/ 2011	1:00 Hr.00 Min.

Supervisory Review / Comments

Signatures	Name	Date
Reporter:		1/00/ 2011
Supervisor:		1/00/ 2011
Program Manager:		1/00/ 2011
Director:		1/00/ 2011
Human Resources:		1/00/ 2011
Medical Provider:		1/00/ 2011
Other:		1/00/ 2011
Other:		1/00/ 2011
Other:		1/00/ 2011