FACILITY/PROGRAM SPECIAL INCIDENT REPORT

Today's= Date:	**Report Completed By:**	
Client Name:	**UCI#:**	**D.O.B.**
Program Name:	**Vendor Number:**	
Program Address:	**City**	**Zip Code:**
Telephone Number:	**Date of Incident:**	**Time of Incident:**
Type of Incident:	**Location of Incident:**	

<u>THIS SECTION FOR ABUSE INCIDENTS ONLY</u>
Perpetrator Name: **Relationship to Client:**

Describe Incident? (Attach a separate sheet of paper, if more space is needed)

Were there any other individuals involved in this incident? □ no □ yes ***(if yes, please list names and titles)***

Did any other individuals witness this incident? □ no □ yes ***(if yes, please list names and titles)***

Was physical containment used? □ no □ yes ***(if yes, please describe)***

Was harm done to the person? □ **no** □ **yes** ***(if yes, please describe)***

Was medical treatment provided? □ **no** □ **yes**
(if yes, please list date, nature of treatment, medical facility, name of who provided treatment)

Preventative action taken (if any):

Indicate vendor action taken so far (e.g.; staff training, policy revision, staff on administrative leave, staff termination)
****For abuse incidents, please submit SIR follow-up report indicating action after investigation by Regional Center, Police and Licensing is completed.***

Agencies Notified	Person Contacted	Date Telephoned	Date Report Submitted	Date of Visit
Regional Center	____________	____________	____________	____________
Licensing (CCL or DHS)	____________	____________	____________	____________
Police	____________	____________	____________	____________
CPS/APS/Ombudsman	____________	____________	____________	____________
Parent/Legal Guardian	____________	____________	____________	____________