



**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:		
<b><u>THIS SECTION FOR ABUSE INCIDENTS ONLY</u></b>			
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? <input type="checkbox"/> no <input type="checkbox"/> yes (if yes, please list names and titles)			
Did any other individuals witness this incident? <input type="checkbox"/> no <input type="checkbox"/> yes (if yes, please list names and titles)			
Was physical containment used? <input type="checkbox"/> no <input type="checkbox"/> 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.*

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