

HOPE GROUP L.L.C.

INCIDENT / ACCIDENT REPORT

*** Complete and submit to Hope Group within 24 hours of incident (phone in immediately).**

Affected Client's Name Age M / F

Affected Employee's Name Job Title

Location of Incident Time of Incident Date of Incident

Describe incident:

What services were being provided and /or activities were being utilized immediately before the incident?

What happened during and / or led up to the incident ? Was any intervention technique being utilized ?

What happened after the incident (including any emergency procedures utilized by employee) ?

Who was involved and / or who witnessed the incident ?

Was there a injury ? Yes___ No___ Was a Physician required ? Yes___ No___ If so, to whom ?_____

Was medical treatment required? Yes___ No___ Location of Treatment_____

Was first aid administered ? Yes___ No___ Was injury serious?_____

Is person served on a behavior management plan ?_____ If yes, was it followed ?_____

Parent / Guardian notified Yes___ No___ Notified by_____

HOPE GROUP notified Yes___ No___ D.D.D. Notified Yes___ No___

Signature of person completing report_____ Date_____

Additional Comments:

Reviewed by: _____

Cc: Case Manager