Provider Name & Address:		

UI/MUI Report Form

Name/Title of Person Completing Form:	
Individual's Name:	DOB:
Address/City:	County:
Date of Incident: Time of Incident: :	
Location of Incident (home in bathroom, at the mall, lunchroom at work):	
Description of Incident (Who, What, Where, When):	
Injury – Describe Type & Location:	
Immediate Action to Ensure Health & Welfare of Individuals:	
Name of PPI(s):	Relationship to Individual:
Witnesses to Incident:	Others Involved:

Type of Notification	**Name/Title**	**Date/Time**
Guardian / Advocate		
SSA (required for Independent Providers)		
Licensed or Certified Provider		
Staff or Family living at the Individual's home & responsible for the individual's care.		
LE (Name, Badge Number, Jurisdiction, and contact information required for Law Enforcement)		
CPSA (Name and contact information required for Children Services)		
County Board		
Provider Notified		
Administrator (Required for ICF)		
Support Broker (If applicable)		

Complete both sides

Cause and Contributing Factors:

Prevention Plan:

Signature **Date**

Additional Information or Administrative Follow-Up:

A. Medical Follow-up:

B. Administrative Action: