



995 Worthington Street, Springfield, MA 01109
Telephone (413) 734-5376 FAX (413) 737-7949

Incident Report

Name of Participant Involved: _____

Staff Name and Title: _____ Date Report Written: _____

Program: _____ Location of Incident: _____

Date and Time of Incident: _____

Other Consumer(s) Involved? Yes No Initial of others: _____

Other Staff Involved? Yes No Initial of others: _____

Description of Incident:

Staff Actions

Who was notified? Please include date and time of notification

APG	Case Manager/Service Coordinator	Cluster on Call
Cluster Director	Key Placement Specialist	Nursing
Police / Fire	Program Supervisor	Program Director
Other: _____		

Staff Signature Title: _____ Date: _____

Forward this to your immediate Supervisor for review. Supervisor, please forward a copy to QIC before Completing Page 2

****Supervisor Review

Was this a critical incident? Yes No

Was notification to DDS made? Yes No When: _____

Was incident reported in HCSIS? Yes No When: _____ if yes, please attach report



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Was a Critical Incident communicated to DMH? Yes No When: _____ if yes, please attach report

Were other entities or funders contacted? If so, who & when _____, attach supplement reports

Comments or Additional Actions

Signature of Program Supervisor and Date: _____

******Program Director Review**

Type of Incident: (Behavior, Assault, Safety, STF) _____

DPPC Status: Filed / Not Applicable

Comments or Additional Actions

Signature of Program Director and Date: _____

******Director Review**

Was Executive Director notified? Yes No When: _____

Investigation Required? Yes No

Comments or Additional Actions

Signature of Director and Date: _____

Please forward entire Incident Report to QIC