

ACADIANA COMMUNITY BASED SERVICES, INC.
Incident/Accident Report Form

Client: _____ Date: _____ Time: _____ AM
PM

TYPE OF INCIDENT/ACCIDENT (Check **ALL** which apply)

<input type="checkbox"/> Fell	<input type="checkbox"/> Bruised	<input type="checkbox"/> Physical Aggression
<input type="checkbox"/> Bumped Head/Face	<input type="checkbox"/> Burned	<input type="checkbox"/> Verbal Aggression
<input type="checkbox"/> Hit Arm/Leg	<input type="checkbox"/> Cut/Scraped	<input type="checkbox"/> Threw Object
<input type="checkbox"/> Destroyed Property	<input type="checkbox"/> Socially/Verbally Inappropriate	
<input type="checkbox"/> Other: Specify _____		

EXACT LOCATION OF INCIDENT/ACCIDENT

<input type="checkbox"/> Kitchen	<input type="checkbox"/> Living Room	<input type="checkbox"/> Yard
<input type="checkbox"/> Bedroom	<input type="checkbox"/> Dining Room	<input type="checkbox"/> Work Site
<input type="checkbox"/> Hall	<input type="checkbox"/> Den	<input type="checkbox"/> School
<input type="checkbox"/> Other: Specify _____		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Undetermined

Describe what may have caused or led up to incident/accident: _____

Describe exactly what happened at time of incident/accident: _____

Action taken by staff: _____

(over)

Client: _____ Date: _____ Time: _____ AM
PM

Witness Name	Address, include street, city, zip
_____	_____
_____	_____
_____	_____

Name legally responsible person: _____

Date and time legally responsible person was contacted: _____

Medical attention required: Yes No First aid only

If YES, name of medical personnel/type of care provided: _____

If YES, date and time medical care was obtained: _____

If YES, describe results and doctor recommendations: _____

ATTACH AVAILABLE REPORTS

Employee Signature Title Date

Program Director Date