AFC LICENSING DIVISION - INCIDENT / ACCIDENT REPORT

Michigan Department of Human Services

Name of Facility/Home	License Number	Name of Person Directly Involved	Resident Employee Visitor
Facility Address		Address	
Facility Phone		City/State/Zip Code	
Licensee Name		Phone	Case Number (if applicable)

OTHER PERSON(S) INVOLVED / WITNESSES:

Name	Resident Employee Visitor	Name	Resident Employee Visitor
Name	Resident Employee Visitor	Name	Resident Employee Visitor

FACTS OF THE INCIDENT (*ATTACH ADDITIONAL PAGES AS NEEDED*):

Date of Incident	Time: : AM PM	Name of Employee Assigned to Resident (if Applicable)	Location of Incident (Kitchen, Yard, etc.)
Explain What Happened / Describe Injury (if any):			
Action taken by Staff / Treatment Given:			
Corrective Measures Taken to Remedy and/or Prevent Recurrence:			

Name of Treating Physician / Health Care / Medical Facility / Hospital	Phone Number	Date Care Given	Time: : AM PM
Physician's Diagnosis of Injury, Illness or Cause of Death, if known			

PERSON(S) NOTIFIED:

AFC Licensing	Notification Date / Time Written Notice / Date	Adult Protective Services (if applicable)	Notification Date / Time
Physician or RN (if applicable)	Notification Date / Time	Office of Recipient Rights (if applicable)	Notification Date / Time
Responsible Agency	Notification Date / Time Written Notice / Date	Law Enforcement Agency (if applicable)	Notification Date / Time
Designated Representative / Legal Guardian	Notification Date / Time Written Notice / Date	Other (please specify)	Notification Date / Time

SIGNATURE(S):

Signature of Person Completing Report	Print Name and Title	Date
Signature of Licensee / Licensee Designee / Administrator	Print Name and Title	Date

COPY DISTRIBUTION: Resident Record, Licensing Consultant, Responsible agency (if required by rule) and Designated representative