UNUSUAL INCIDENT/ INJURY REPORT

INSTRUCTIONS: Notify Licensing agency, placement agency, and responsible Persons, if any, by next working day.

Submit written report within 7 days of occurrence

Retain Copy of Report in Client's File

NAME OF FACILITY	FACILITYFILE NUMBER	TELEPHONE NUMBER
Rainbow Valley Foster Care	247204084	(209) 722-0202

ADDRESS	CITY, STATE, ZIP
2841 G Street	Merced, CA 95340

CLIENTS/RESIDENTS INVOLVED	DATE OCCURRED	BIRTHDATE	SEX	DATE OF ADMISSION

FOSTER HOME INVOLVED	ADDRESS	PHONE

TYPE OF INCIDENT ☐

- ☐ **Unauthorized Absence**
- ☐ **Aggressive Act/Self**
- ☐ Aggressive Act/Another Client
- ☐ Aggressive Act/Staff
- ☐ Aggressive Act/Family, visitors
- ☐ Alleged Violation of Rights
- ☐ Alleged Client Abuse
- ☐ Sexual
- ☐ Physical
- ☐ Psychological
- ☐ Financial
- ☐ Neglect
- ☐ Rape
- ☐ Pregnancy
- ☐ Suicide Attempt
- ☐ Other
- ☐ Injury-Accident
- ☐ Injury-Unknown Origin
- ☐ Injury-From another Client
- ☐ Injury-behavior episode
- ☐ Epidemic Outbreak
- ☐ Hospitalization
- ☐ Medical Emergency
- ☐ Other Sexual Incident
- ☐ Theft
- ☐ Fire
- ☐ Property Damage
- ☐ Other (explain)

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTECEDENTS LEADING UP TO INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY INJURIES

PERSONS OBSERVING INCIDENT/INJURY:

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CONTACTED:

MEDICAL TREATMENT NECESSARY YES ☐ NO ☐ IF YES, GIVE NATURE OF TREATMENT	
WHERE ADMINISTERED:	ADMINISTERED BY:
FOLLOW UP TREATMENT , IF ANY:	
ACTION TAKEN OR PLANNED (BY WHOM AND ANTICIPATED RESULTS:	
LICENSEE/SUPERVISOR COMMENTS:	
NAME OF ATTENDING PHYSICIAN	

REPORT SUBMITTED BY:	NAME AND TITLE:	DATE:
REPORT REVIEWED/ APPROVED BY:	NAME AND TITLE:	DATE:

AGENCIES/INDIVIDUALS NOTIFIED (SPEDIFY NAME AND TELEPHONE NUMBER)

☐ LICENSING e-mail notification
☐ ADULT/CHILD PROTECTIVE SERVICES ____
☐ LONG TERM CARE OMBUDSMAN ____
☐ LAW ENFORCEMENT _____
☐ PARENT/GUARDIAN/CONSERVATOR ____
☐ PLACEMENT AGENCY