Possible or Determined MUI/UI Report Form

(please print legibly)

Provider Name:			
Contact Person (if agency):		Phone:	
Provider address:		Provider email:	
Individual's Name:		DOB:	
Address:		City/County:	

Date of Incident: Time of Incident: AM ☐ PM ☐

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:

Contributing Factors (what led to this incident occurring):

Signature:		**Date**	
Name of PPI(s):		Relationship to Individual:	
Witness to Incident: (include witness statement)		Others Involved:	

Type Of Notification	Name of person notified	Date/Time	Notified By:	How notified (email, phone, fax, etc)
Guardian/Advocate				
SSA / Path Coordinator / QMRP				

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Licensed or Certified Provider				
Staff or Family living at the individual's home and responsible for the individual's care				
Law Enforcement/Children's Protective Services (include officer's name or badge #)				

Type Of Notification	Name	Date/Time	By:	Copy Sent
County Board				
Director				
Other				

A. Administrative Action:

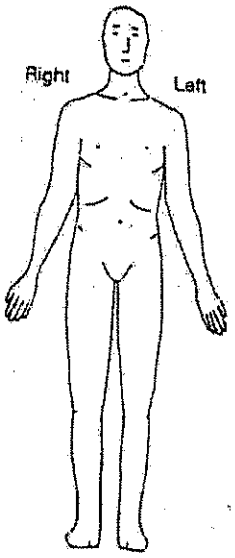
B. Medical Summary/further medical follow up:

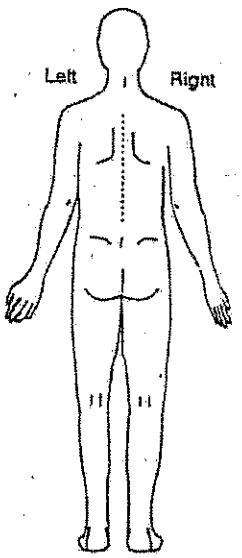
Signature/Title (if different than reporter) Date

Time of Assessment:

Body Part Injured:

- ☐ Head or Face
- ☐ Mouth / Teeth
- ☐ Hands / Arms
- ☐ Feet / Legs
- ☐ Other
- ☐ Neck or Chest
- ☐ Abdomen
- ☐ Back / Buttocks
- ☐ Genitals





C. Follow Up/Prevention Statement:

Signature (QMRP/Coordinator/Director) : **Date:**