



FACILITY INFORMATION	FACILITY NAME	FACILITY LICENCE NUMBER	
	ADDRESS	PHONE NUMBER	
PERSONS INVOLVED	NAME OF PERSON IN CARE (1)	DATE OF BIRTH DD/MMM/YYYY	SEX <input type="checkbox"/> M <input type="checkbox"/> F
	NAME OF PERSON IN CARE (2)	DATE OF BIRTH DD/MMM/YYYY	SEX <input type="checkbox"/> M <input type="checkbox"/> F
	<input type="checkbox"/> STAFF <input type="checkbox"/> VISITOR <input type="checkbox"/> OTHER (SPECIFY)		NUMBER OF PERSONS IN CARE AFFECTED

TYPE OF INCIDENT BEING REPORTED: <input type="checkbox"/> AGGRESSIVE/UNUSUAL BEHAVIOUR <input type="checkbox"/> AGGRESSION BETWEEN PERSONS IN CARE [Res. Care Only] <input type="checkbox"/> ATTEMPTED SUICIDE <input type="checkbox"/> CHOKING DEATH <input type="checkbox"/> EXPECTED <input type="checkbox"/> UNEXPECTED <input type="checkbox"/> DISEASE OUTBREAK <input type="checkbox"/> EMERGENCY RESTRAINT <input type="checkbox"/> EMOTIONAL ABUSE <input type="checkbox"/> FALL <input type="checkbox"/> FINANCIAL ABUSE <input type="checkbox"/> FOOD POISONING <input type="checkbox"/> MEDICATION ERROR <input type="checkbox"/> MISSING/WANDERING <input type="checkbox"/> MOTOR VEHICLE INJURY <input type="checkbox"/> NEGLIGENCE <input type="checkbox"/> POISONING <input type="checkbox"/> PHYSICAL ABUSE <input type="checkbox"/> SERVICE DELIVERY PROBLEMS <input type="checkbox"/> SEXUAL ABUSE <input type="checkbox"/> UNEXPECTED ILLNESS <input type="checkbox"/> OTHER INJURY _____	INDICATE TYPE OF INJURY BEING REPORTED & EQUIPMENT INVOLVED: TYPE OF INJURY (all service types to complete): <input type="checkbox"/> BRUISE/CONTUSION <input type="checkbox"/> DISLOCATION <input type="checkbox"/> SPRAIN/STRAIN <input type="checkbox"/> BURN <input type="checkbox"/> FRACTURE <input type="checkbox"/> SURFACE CUT/SCRATCH <input type="checkbox"/> CONCUSSION <input type="checkbox"/> LACERATION/ABRASION <input type="checkbox"/> OTHER _____ <input type="checkbox"/> NO INJURY EQUIPMENT (child care only): <input type="checkbox"/> SWING <input type="checkbox"/> SLIDING POLE <input type="checkbox"/> SLIDE <input type="checkbox"/> HORIZONTAL LADDER/MONKEY BARS <input type="checkbox"/> SEESAW <input type="checkbox"/> ROPE-LADDER <input type="checkbox"/> COMPOSITE CLIMBER <input type="checkbox"/> OTHER _____	LOCATION OF INCIDENT CHOOSE ONE OF THE FOLLOWING: <input type="checkbox"/> RESIDENTIAL CARE <input type="checkbox"/> CHILD CARE - INDOOR EXCLUDING PLAYGROUND <input type="checkbox"/> CHILD CARE - INDOOR PLAYGROUND <input type="checkbox"/> CHILD CARE - OUTDOOR EXCLUDING PLAYGROUND <input type="checkbox"/> CHILD CARE - OUTDOOR PLAYGROUND																													
		<table border="0"> <tr> <td>NOTIFIED</td> <td>DATE</td> <td>TIME</td> </tr> <tr> <td>HEALTH CARE PROVIDER</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>POLICE</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>LICENSING/MHO</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>CORONER</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>OTHER (SPECIFY)</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>AMBULANCE</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>MCF</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>MANAGER</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>FIRE DEPARTMENT</td> <td>_____</td> <td>_____</td> </tr> </table>		NOTIFIED	DATE	TIME	HEALTH CARE PROVIDER	_____	_____	POLICE	_____	_____	LICENSING/MHO	_____	_____	CORONER	_____	_____	OTHER (SPECIFY)	_____	_____	AMBULANCE	_____	_____	MCF	_____	_____	MANAGER	_____	_____	FIRE DEPARTMENT
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PARENT/REPRESENTATIVE/CONTACT PERSON CONTACTED <input type="checkbox"/> YES <input type="checkbox"/> NO DATE/TIME _____ NAME OF PERSON NOTIFIED _____ PHONE NUMBER _____																															

DETAILS OF INCIDENT AND FOLLOW UP (ATTACH ADDITIONAL PAGES IF NECESSARY)

DATE OF INCIDENT	TIME OF INCIDENT	INDICATE SERVICE TYPE (If applicable):

SIGNATURES	NAME	POSITION	SIGNATURE	DATE	TIME
Witness/Attending Staff:					
Form Completed by:					
Licensee/Manager					

Reported to Licensing	THIS SECTION TO BE COMPLETED BY THE LICENSING OFFICER UPON RECEIPT OF REPORT (ATTACH ADDITIONAL PAGES IF NECESSARY)	
Day/Month/Year	NOTIFICATION COMMENTS	

Type of Incident Confirmed by Licensing	<input type="checkbox"/> AGGRESSIVE/UNUSUAL BEHAVIOUR <input type="checkbox"/> ATTEMPTED SUICIDE <input type="checkbox"/> DEATH EXPECTED <input type="checkbox"/> DISEASE OUTBREAK <input type="checkbox"/> EMERGENCY RESTRAINT <input type="checkbox"/> EMOTIONAL ABUSE <input type="checkbox"/> MEDICATION ERROR <input type="checkbox"/> MOTOR VEHICLE INJURY <input type="checkbox"/> OTHER INJURY <input type="checkbox"/> POISONING <input type="checkbox"/> SERVICE DELIVERY PROBLEMS <input type="checkbox"/> NO INCIDENT CONFIRMED	<input type="checkbox"/> AGGR. BTWN PERSONS IN CARE (res. care only) <input type="checkbox"/> CHOKING <input type="checkbox"/> DEATH UNEXPECTED <input type="checkbox"/> FALL <input type="checkbox"/> FINANCIAL ABUSE <input type="checkbox"/> FOOD POISONING <input type="checkbox"/> MISSING/WANDERING <input type="checkbox"/> NEGLIGENCE <input type="checkbox"/> PHYSICAL ABUSE <input type="checkbox"/> SEXUAL ABUSE <input type="checkbox"/> UNEXPECTED ILLNESS	<div style="border: 1px solid black; padding: 5px;"> Residential Care Licensing Officers complete this box if confirmed MISSING/WANDERING or AGGR. BTWN PIC: OUTCOME: <input type="checkbox"/> NOT FOUND [Missing/wandering only] <input type="checkbox"/> UNHARMED [Missing/wandering only] <input type="checkbox"/> FIRST AID PROVIDED [Missing/wandering only] <input type="checkbox"/> EMERG. Care by MD, NP or Transfer to Hospital <input type="checkbox"/> DEATH </div>
	<input type="checkbox"/> Reported to Coroner by Facility <input type="checkbox"/> Reported to Coroner after Licensing Review <input type="checkbox"/> Not Reported to Coroner		

Confirm Type of Injury & Equipment	TYPE OF INJURY: <input type="checkbox"/> BURN <input type="checkbox"/> FRACTURE <input type="checkbox"/> BRUISE/CONTUSION <input type="checkbox"/> CONCUSSION <input type="checkbox"/> DISLOCATION <input type="checkbox"/> SPRAIN/STRAIN <input type="checkbox"/> LACERATION/ABRASION <input type="checkbox"/> SURFACE CUT/SCRATCH <input type="checkbox"/> OTHER _____ <input type="checkbox"/> NO INJURY	EQUIPMENT (Child Care Playground Incidents): <input type="checkbox"/> COMPOSITE CLIMBER <input type="checkbox"/> SEESAW <input type="checkbox"/> HORIZ. LADDER/ MONKEY BARS <input type="checkbox"/> SLIDE <input type="checkbox"/> ROPE-LADDER <input type="checkbox"/> SLIDING POLE <input type="checkbox"/> SLIDING POLE <input type="checkbox"/> OTHER _____
	Indicate Service Type Confirmed: _____	

Licensing Follow-Up	<input type="checkbox"/> No Follow-up Required by Licensing <input type="checkbox"/> Follow-up Required by Licensing <input type="checkbox"/> Licensing Follow-up Complete: DD/MMM/YYYY <input type="checkbox"/> Not a Reportable Incident		
	COMMENTS:		
Licensing Officer's Name [Print]	Signature	Date	Page ___ of ___