ATTACHMENT B

INCIDENT OR UNUSUAL INCIDENT REPORT

DATE OF REPORT:	TIME: ☐ A.M. ☐ P.M.

NAME OF CLIENT (Last, First, M.I.):	PROVIDER NAME: The Arc
ADDRESS:	ADDRESS: 115 Meadow Ave.
CITY: STATE: ZIP CODE:	CITY: Scranton STATE: PA ZIP CODE: 18505
PHONE:	PHONE: (570) 346-4010
B.S.U. NUMBER:	COUNTY WHERE FACILITY IS LOCATED: Lackawanna
DATE OF BIRTH: / SEX: ☐ Male ☐ Female	DATE OF ADMISSION:
LEVEL OF MENTAL RETARDATION:	DATE OF INCIDENT: / TIME: ☐ A.M. ☐ P.M.
LOCATION OF INCIDENT (Bathroom, Hall, Program Area, etc.):	FACILITY/AGENCY LICENSE NUMBER: 186

DESCRIBE IN DETAIL EXACTLY WHAT HAPPENED AND ANY CIRCUMSTANCES WHICH MAY HAVE PRECIPITATED THE INCIDENT/UNUSUAL INCIDENT: (ATTACH ADDITIONAL SHEETS IF NECESSARY)

DESCRIPTION OF ANY INJURY:

PHYSICIAN'S NAME AND STATEMENT (if applicable) – INCLUDE TREATMENT AND FOLLOW-UP ACTION:

ACTION TAKEN:

OTHER PERTINENT INFORMATION (Seizures, Visual Impairment, Safety conditions, etc.):

RELATIVE OR GUARDIAN NOTIFIED:	RELATIONSHIP:	ADDRESS:	PHONE:

TYPED/PRINTED NAME AND SIGNATURE OF PERSON REPORTING:		TITLE:	PHONE:
TYPED NAME:	SIGNATURE:		

DATE MAILED TO:

_____ REGIONAL OFFICE OF MENTAL RETARDATION
_____ COUNTY MENTAL RETARDATION OFFICE
_____ FUNDING AGENCY (Specify) _____
_____ OFFICE OF CHILDREN, YOUTH & FAMILIES (Early Intervention)
_____ DEPARTMENT OF HEALTH (ICF/MR)

DATE AND TIME NOTIFIED IF ABUSE OR SUSPECTED ABUSE OF A CLIENT; AN INCIDENT REQUIRING THE SERVICES OF A FIRE DEPARTMENT OR A LAW ENFORCEMENT AGENCY; OR CONDITION RESULTING IN CLOSURE FOR MORE THAN ONE DAY OF OPERATION OCCURS:

_____ REGIONAL OFFICE OF MENTAL RETARDATION
_____ COUNTY MENTAL RETARDATION OFFICE
_____ FUNDING AGENCY (Specify) _____
_____ OFFICE OF CHILDREN, YOUTH & FAMILIES (Early Intervention)
_____ DEPARTMENT OF HEALTH (ICF/MR)