REFERENCE #_______

WNYIL, INC. INCIDENT REPORT

This report **must** be filled out within **24-hours** of an Incident by a person involved or who witnessed an Incident. If more than one person is involved, a separate report should be completed for each person involved. The completed form should be immediately turned-in to the staff person's Supervisor who will then forward it to the Human Resources Coordinator.

1. Name of Person in Incident:			
2. Address of Person in Incident:			
3. Phone # of Person in Incident:			
4. Relationship to WNYIL: ☐ Staff ☐ Volunteer/Intern ☐ Consumer ☐ Visitor			
5. Involved Person's Supervisor:			
6. Date of Incident:	Time of Incident: AM PM			
7. Start of Shift: AM PM	End of Shift: AM PM			
8. Name(s), address(es), & Phone Number(s) of Witness(es) (if any)			
9. Type of Incident:	☐ Abuse/Neglect ☐ Fall/Slip ☐ Car Accident	☐ Assault/Fight ☐ Illness ☐ Theft	☐ Bending ☐ Lifting ☐ Other: ___________
10. List Body Part(s) Affected:			
11. Location or Address of Incident:			
12. Describe Incident in Detail: (Include any tools, equipment, materials, etc. that were involved in the Incident).			
13. Were EMS Contacted?	☐ Yes	☐ No	☐ N/A
14. Was a Police Report Filed?	☐ Yes	☐ No	☐ N/A
15. Is the Person in Incident going for treatment? If yes, Name/Address of Care Provider:	☐ Yes	☐ No	☐ Unknown

16. Corrective Action:	
17. Date of Corrective Action Plan:	
18. Involved Person's Signature:	Date Signed:
19. Supervisor's Signature:	Date Report Reviewed:
20. CEO Signature:	Date Report Reviewed:
Office Use Only:	
Incident Category: ☐ Staff ☐ Personal Care Assistant ☐ Volunteer/ Intern ☐ Facility ☐ Consumer ☐ Transportation ☐ Visitor	
Date Office Receives Form:	
Office Notes:	
Date HR Receives Form:	
HR Notes:	
☐ Program Committee ☐ Human Resources ☐ Corporate Compliance	
Care Coordination Agency Contacted: ☐Yes ☐No ☐N/A	
If Yes, Date of contact:	
Care Coordination Agency Contact Information:	
Past Incidents: ☐Yes ☐No ☐N/A	
If Yes, Provide Date and Description Of The Incident:	
Social Security Number:	
Average Weekly Wage:	
Job Title:	
Job Duties:	
Date of Hire:	
Typical Work Days: ☐Sun ☐Mon ☐Tue ☐Wed ☐Thu ☐Fri ☐Sat	
Lost Time from Work: ☐Yes ☐No ☐N/A	
If yes, Last Day Worked:	
First Scheduled Day Out of Work:	
If applicable, Return to Work Date:	