REFERENCE #_____

WNYIL, INC. INITIAL INCIDENT REPORT FORM

This Incident Report Form **must** be filled out within **24-hours** of an Incident by a person involved in, who witnessed, or who was told of an Incident. If more than one person is involved, a separate Initial Incident Report Form should be completed for each person involved. The completed Initial Incident Report Forms(s) should be immediately turned-in to the staff person's Supervisor who will then forward it/them to the MIRT Team at mirt@wnyil.org.

1. Name of Person in Incident:				
2. Address of Person in Incident:				
3. Phone # of Person in Incident:				
4. Relationship of person to WNYIL: ☐ Staff	☐ Volunteer/Intern	☐ Consumer	☐ Visitor	
5. Oversight Reporting Obligation: ☐ CDPAS	☐ OPWDD	☐ Health Homes		
☐ OASAS	☐ HCBS/CORE	☐ Other	☐ VDC	☐ N/A
6. Involved Person's Supervisor (if applicable):				
7. Date Incident Occurred:	Time Incident Occurred:	AM	PM	
8. Date Incident Reported:	Time Incident Reported:	AM	PM	
9. Start of Shift: AM PM | End of Shift:		AM	PM	
10. Name(s), Address(es), & Phone Number(s) of Witness(es) (if any):				
11. Type of Incident: ☐ Abuse/Neglect/Harm/Death	☐ Assault/Fight	☐ Bending		
☐ Fall/Slip	☐ Illness	☐ Lifting		
☐ Car Accident	☐ Theft	☐ Other		
12. List Body Part(s) Affected:				
13. Location or Address of Incident:				
14. Describe Incident in Detail: (Include any tools, equipment, materials, etc. that were involved in the Incident). Include additional paper if necessary.				
15. Were EMS Contacted?	☐ Yes	☐ No	☐ N/A	
16. Was a Police Report Filed?	☐ Yes	☐ No	☐ N/A	
17. Is the Person in Incident Going for Treatment?	☐ Yes	☐ No	☐ Unknown	
If Yes, Name/Address of Care Provider:				

18. Corrective Action Plan:		
19. Date of Corrective Action Plan:		
20. Involved Person's Signature:	Date Signed:	
21. Supervisor's Signature:	Date Report Reviewed:	
22. Program:	Department:	
23. CEO Signature:	Date Report Reviewed:	
OFFICE USE ONLY		
Incident Category: ☐ Staff ☐ Personal Care Assistant ☐ Volunteer/ Intern ☐ Facility ☐ Consumer ☐ Transportation ☐ Visitor		
Incident Entered into IRMA//NIMRS/IRAMS: ☐Yes ☐No ☐N/A		
Date Office Received Form:		
Office Notes:		
Date HR Receives Form:		
HR Notes:		
☐ Program Committee ☐ Human Resources ☐ Corporate Compliance		
Care Coordination Organization Contacted (if applicable): ☐Yes ☐No ☐N/A		
If Yes, Date of contact:		
Care Coordination Organization Contact Information:		
Past Incidents: ☐Yes ☐No ☐N/A		
If Yes, Provide Date(s) and Description(s) of the Incident(s):		
Social Security Number:	Average Weekly Wage:	
Job Title:		
Job Duties:		
Date of Hire:		
Typical Workdays: ☐Sun ☐Mon ☐Tue ☐Wed ☐Thu ☐Fri ☐Sat		
Lost Time From Work: ☐Yes ☐No ☐N/A		
If Yes, Last Day Worked:		

REFERENCE #_____

First Scheduled Day Out of Work:
If Applicable, Return to Work Date: