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 ☐ 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? If Yes, Name/Address of Care Provider:	☐ Yes	☐ No	☐ Unknown

17. Corrective Action Plan:		
18. Date of Corrective Action Plan:		
19. Involved Person's Signature:	Date Signed:	
20. Supervisor's Signature:	Date Report Reviewed:	
21. Program:	Department:	
22. CEO Signature:	Date Report Reviewed:	
OFFICE USE ONLY		
Incident Category: ☐ Staff ☐ Facility ☐ Visitor	☐ Personal Care Assistant ☐ Consumer	☐ Volunteer/ Intern ☐ Transportation `
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:		
First Scheduled Day Out of Work:		
If Applicable, Return to Work Date:		