2700 W Dublin Granville Rd, Ste 10., Columbus Ohio 43231
Email: info@ecsohio.org

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INCIDENT REPORT

Provider Name & Address: EMPATHY CARE SERVICE (LLC *2700 W Dublin Granville Rd, Ste 10., Columbus Ohio 43231*

Individual's Name:	DOB:
Address:	City/County:

Date of Incident: Time of Incident: ☐ AM ☐ PM

Location of Incident (home in bathroom, at the mall, lunchroom at work):

Description of Incident (Who, What, Where, When):

Injury – Describe Type & Location:

Immediate Action to Ensure Health & Welfare of Individuals:

Name of PPI(s):	Relationship to Individual:
Witnesses to Incident:	Others Involved:

Person Notified	Name of Person	Date Contacted	Time contacted	Person reporting
Director of DD service				
Home Supervisor				
Case Manager				
Parent/ Family/ Advocate				

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Support Co-Ordinator				
Physician				
Social Worker				
Law Enforcement				
Executive Director				
Other Providers of Service				

Additional Information/or Administrative Follow-Up:

A. Further Medical Follow-up:

B. Administrative Action:

Printed Name: ______________________________

Signature: ______________________________ Title: ______________________ Date: _________________

Body Part Injured:

- ☐ Head or Face
- ☐ Mouth / Teeth
- ☐ Hands/Arms
- ☐ Feet/Legs
- ☐ Neck or Chest
- ☐ Abdomen
- ☐ Back/Buttocks
- ☐ Genitals

Detailed description of area(s) injured:

____
____
____
____
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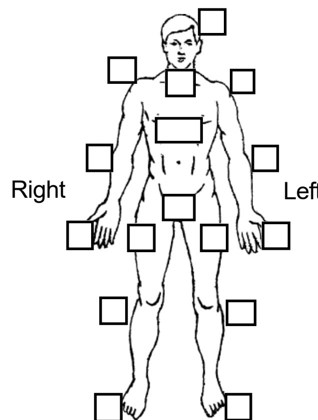
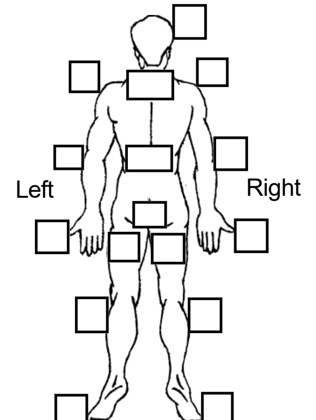
____
____
____
____
____

Check All Areas Injured

Anterior



Posterior



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Causes and Contributing Factors:
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____

Preventive measures: (For Provider's internal use)
____
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____
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Supervisor Review: ______________________________ Date: ______________________