Portage DD
THE PORTAGE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Incident - UI and/or MUI - Report Form *(For use by Agency/Independent Providers)*

Provider Name & Address:

Name of Person-Served:	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 the Person-Served:

Name of PPI(s):	Relationship to Person-Served:
Witnesses to Incident:	Others Involved:

Type of Notification	Name/Title	Date/Time
Guardian/Advocate/Family		
SSA		
Licensed or Certified Provider		
Staff or Family living at the person-served home		
LE (Name, Badge Number, Jurisdiction, Contact Info)		
Children's Services (if applicable)		
County Board/Townhall II (330-678-7559)		
Administrator (Required for ICF)		
Senior Management		
Other Providers of Service		

Printed Name of Person Completing Form Above: ______________________________ Date:__________________

Title: ____

Additional Information / Administrative Follow-Up:

A. Further Medical Follow-up:

B. Administrative Action:

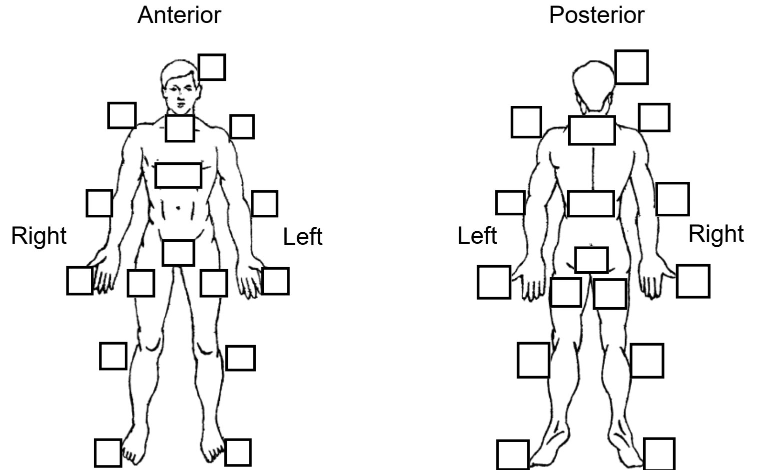
Printed Name: ____________________________ Title: ____________________ Date:_______________

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:

Check All Areas Injured



Causes and Contributing Factors:

Preventive measures: (For Provider's Internal Use)

Administrator Review: _______________________________ Date: _________________________