Champlain Community Services

INCIDENT REPORT

Type of Incident: (*leave blank if unsure)*

_____ **MEDICAL** _____ **OTHER**

Name: _____ Date: _____ Time:_____

Person(s) Reporting: _____

Location of Incident:_____

Others Involved: _____

Type of Incident: _____

Description of Incident:

_____
_____
_____
_____
_____
_____

Action Taken:

_____
_____
_____

Who Notified: _____

SUPERVISOR REVIEW

Follow-Up Needed: Yes ___ No ____
Describe:

_____
_____
_____

Received at CCS: Date: _____By _____

512 Troy Ave, Suite 1, VT 05446 phone 802-295-1658, fax 802-295-0663