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Washington County Health & Human Services INCIDENT REPORT

| Agency Name: | WCHHS | WCHHS Case Manager: | | |
|----------------------------------------------------------------|--------------------------|--------------------------------|--|--|
| Client Name | Date of Incident | Time of Incident a.m. | | |
| Accident Injury Illi | ness Unusual Incident | Complaint/Grievance Other | | |
| DESCRIPTION OF ACCIDE Record specific details including dates, | | | | |
| | | | | |
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| | | | | |
| | | | | |
| Signature of Staff Member Making I | Report | Date | | |
| ADMINISTRATIVE REVIEW, INCLU | JDING STEPS TAKEN TO PRE | EVENT A RECURRENCE OF INCIDENT | | |
| | | | | |
| | | | | |
| | | | | |
| Signature Date mailed to CMHP | Position | Date | | |