Provider Agency Name & Address:

DODD – Possible or Determined MUI Report Form

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 & Safety of Individuals:

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

Type of Notification	Name/Title	Date
Guardian / Advocate		
SSA		
Licensed or Certified Provider		
Staff or Family living at the individual's home & responsible for the individual's care.		
LE	(Name and contact information required for Law Enforcement)	
CPSA	(Name and contact information required for Children Services)	
County Board		

Additional Information/or Administrative Follow-Up:

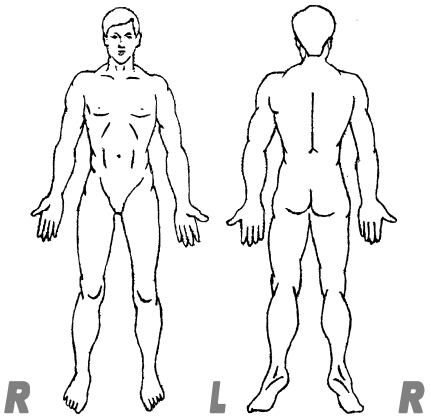
A. Further Medical Follow-up:

B. Administrative Action:

Signature: Date:

Body Part Injured:

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



Preventive measures: (For Provider's internal use)