

INCIDENT, ACCIDENT, ILLNESS, DEATH OR FIRE REPORT STATE OF MICHIGAN

Department of Human Services
Bureau of Children and Adult Licensing

INSTRUCTIONS

- The completion of this form may optionally be used to document the requirements of the following licensing rules:

Child Care Centers R 400.5111, R 400.5865

Children's and Adult Foster Care Camps R 400.11227

Child Placing Agencies R 400.12415 (2)

Child Caring Institutions R400.4167(1)(2)

Juvenile Facilities R400.10159(2)

Family and Group Child Care Homes R400.1808(1)(2)

- The completion and submission of this form to the Agency is required by the following licensing rules:

Child Care Centers R 400.5111 (2)

Children's and Adult Foster Care Camps R 400.11127 (6)

FACILITY/HOME/PROVIDER:

LICENSING CONSULTANT:

License Number	Facility/Home/Provider Phone Number ()	FACILITY TYPE:	Licensing Consultant Name
Facility/Home/Provider Name		<input type="checkbox"/> Child Care Home	
Address (Street Number and Name)	County	<input type="checkbox"/> Child Care Center	
City	State	<input type="checkbox"/> Camp	
	Zip Code	<input type="checkbox"/> Child Caring Institution	
		<input type="checkbox"/> Juvenile Detention	

PERSON(S) IN CARE INVOLVED:

Name	Name
Age	Age
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Address If Other Than Facility/Home Address (Street Number & Name)	Home Address If Other Than Facility/Home Address (Street Number & Name)
City	City
State	State
Zip Code	Zip Code
Home Phone Number If Other Than Facility/Home ()	Home Phone Number If Other Than Facility/Home ()
Name of Parent (if minor)	Name of Parent (If Minor)
Work Phone Number ()	Work Phone Number ()

OTHER PERSON(S) INVOLVED / WITNESS(ES):

Name	Name
Address (Street Number and Name)	Address (Street Number and Name)
Phone Number ()	Phone Number ()

DISTRIBUTION:

CHILD PLACING AGENCY:

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Referring Agency

CHILD CARING INSTITUTION:

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Resident Record

JUVENILE FACILITY:

Part 1 - Licensing Consultant

Part 2 - Referring Agency

FAMILY AND GROUP CHILD CARE HOME:

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Home Record

CHILD CARE CENTER:

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Center Record

CHILDREN'S AND ADULT FOSTER CARE CAMP:

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Camper's Record

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 1973 PA 116
COMPLETION: Voluntary/Mandatory
PENALTY: May be in violation of administrative rule.

PERSON(S) NOTIFIED:

Name of Person Notified		Notification Date	Notification Time	Non-Applicable
Physician			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Referring/Responsible Agency (Child Caring Institution Only)			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Probate Court (Juvenile Detention Only)			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Law Enforcement Agency			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Fire Marshal			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Local Coroner			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Family Member			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Other (Specify)			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Incident, Accident, Illness, Death or Fire	Date:	Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Location:	
Description, Cause, Surrounding Circumstances				

If Fire, State Extent of Damage				N/A
				<input type="checkbox"/>
First Aid Given and When, if Applicable				<input type="checkbox"/>
Who Provided First Aid, if Applicable				<input type="checkbox"/>
Other Action Taken				

Physician's Diagnosis of Injury or Illness, if Applicable				<input type="checkbox"/>
Name of Treating Physician, Medical Facility, Hospital, if Applicable				<input type="checkbox"/>
Phone Number of Treating Physician, Medical Facility, Hospital, if Applicable				<input type="checkbox"/>
Cause of Death, if Applicable	Was an Autopsy Performed <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>
Were Any Handicaps, Health Problems, or Exceptions Listed on the Child's Health Records? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Signature of Person Completing This Report		Title	Date	
Signature of Licensee/Responsible Person		Title	Date	