HARBOR REGIONAL CENTER
Service Provider Special Incident Report
Send to: **SIRS@harborrc.org**
Reports must be submitted within 48 hours

Individual's Name:_____	**DOB:**_____	**UCI#:**_____
HRC Service Coordinator:_____		
Service Provider Name:_____	**Vendor #:**_____	
Date Incident Occurred:_____	**Time of Incident:**_____	
Date Vendor Learned of Incident:_____		

Location of Incident:

Hospital ☐	Client's Residence ☐	Client's Day Program ☐	Family Home ☐
In Transit ☐	Emergency Room ☐	Other (specify) ☐ _____	

INCIDENT TYPE (check all that apply):

☐ **Death:**

Official Cause of Death:_____

☐ **Victim of a crime:**

Was the crime reported to the police? Yes ☐ No ☐

Police Department:_____

Report Number:_____

☐ **Admitted to the Hospital for more than 24 hours:**

Admitting Diagnosis:_____

☐ **Individual has a serious injury or accident requiring treatment beyond first aid.**

☐ **Missing Individual:**

Police Department:_____

Report Number:_____

How long has the individual been missing? _____

☐ **Abuse of the Individual:**

Physical ☐ Sexual ☐ Financial ☐ Chemical Restraint ☐ Emotional ☐

☐ **Neglect of Individual**

☐ **Medication Error**

HARBOR REGIONAL CENTER
Service Provider Special Incident Report
Send to: **SIRS@harborrc.org**
Reports must be submitted within 48 hours

Describe in detail what happened and actions taken

Did anyone else witness the incident? Yes □ No □

Name and contact information (phone & email) of the witness, if available:

_____

Other agencies notified:

CCL/DSS □ DHS □ Parent/Guardian/Conservator □ Physician/Hospital □

Police/Sheriff □ County Coroner □ Other (specify) □ _____

Date reported to CCL/DHS: _____

Submitted by:

Name:_____ Title:_____

Telephone #:_____ Email:_____

HARBOR REGIONAL CENTER
Service Provider Special Incident Report
Send to: **SIRS@harborrc.org**
Reports must be submitted within 48 hours

Please use this space below to add any other information you think is important about the special incident: