

**INCIDENT REPORT
STATE OF MICHIGAN**
Michigan Department of Licensing and Regulatory Affairs
Child Care and Camps

INSTRUCTIONS

COMPLETION AND SUBMISSION

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

Family and Group Child Care Homes R 400.1962(2)

Child Care Centers R 400.8158(3)

Children's and Adult Foster Care Camps R 400.11127(9)

DISTRIBUTION

Send original to your licensing consultant and retain a copy for your records.

Was the incident phoned to licensing?

☐ Yes If yes, date and time? _____

☐ No If no, contact your licensing consultant within 24 hours of the incident.

TYPE OF REPORT

<input type="checkbox"/> Incident	<input type="checkbox"/> Accident	<input type="checkbox"/> Illness	<input type="checkbox"/> Death	<input type="checkbox"/> Fire
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FACILITY

Registration/License Number		Facility Phone Number ()		Facility Type <input type="checkbox"/> Family Child Care Home <input type="checkbox"/> Group Child Care Home <input type="checkbox"/> Child Care Center <input type="checkbox"/> Children's Camp <input type="checkbox"/> Adult Foster Care Camp	
Facility/Home/Provider Name					
Address (Street Number and Name)		County			
City	State	Zip Code			

CHILD(REN) IN CARE INVOLVED

Name			Name		
Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Home Address (Street Number & Name)			Home Address (Street Number & Name)		
City	State	Zip Code	City	State	Zip Code
Name of Parent			Name of Parent		
Home Phone Number ()	Alternative Phone Number ()		Home Phone Number ()	Alternative Phone Number ()	

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

Name		Name	
Address (Street Number, Name, City)		Address (Street Number, Name, City)	
Phone Number ()		Phone Number ()	

INCIDENT DETAILS

Incident Date	Time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Location
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Describe the incident. Be specific.

Describe the incident (cont.).		
Was First Aid Given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If yes, when?	By whom?
Child's Illness or Injury, if applicable		
Where Child Received Medical Treatment, if applicable and known		
Phone Number of Treating Physician / Medical Facility / Hospital, if applicable		
Any Handicaps, Health Problems, or Exceptions Listed on the Child's Health Records, if applicable		
If Fire, Describe Damage		

PERSON(S) NOTIFIED (law enforcement, fire marshal, parent/legal guardian, etc.)

Name of Person Notified	Notification Date	Notification Time
		: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
		: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
		: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.

Signature of Person Completing This Report	Title	Date
Signature of Registrant/Licensee/Responsible Person	Title	Date

LARA is an equal opportunity employer/program.	AUTHORITY: 1973 PA 116 COMPLETION: Mandatory PENALTY: May be in violation of licensing rule.
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