San Gabriel / Pomona Regional Center

FACILITY/PROGRAM SPECIAL INCIDENT REPORT

Today's Date:		**Report Completed By:**	
Client Name:		**UCI#:**	**D.O.B.**
Program Name:		**Vendor Number:**	
Program Address:		**City**	**Zip Code:**
Telephone Number:	**Date of Incident:**	**Time of Incident:**	
Type of Incident:	**Location of Incident:**		
THIS SECTION FOR ABUSE INCIDENTS ONLY **Perpetrator Name:**		**Relationship to Client:**	
Describe Incident? (Attach a separate sheet of paper, if more space is needed)			
Were there any other individuals involved in this incident? □**no** □**yes** ***(if yes, please list names and titles)***			
Did any other individuals witness this incident? □**no** □**yes** ***(if yes, please list names and titles)***			
Was physical containment used? □**no** □**yes** ***(if yes, please describe)***			

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Was harm done to the person? □**no** □**yes** ***(if yes, please describe)***

Was medical treatment provided? □**no** □**yes**
(if yes, please list date, nature of treatment, medical facility, name of who provided treatment)

Preventative action taken (if any):

Indicate vendor action taken so far (e.g.; staff training, policy revision, staff on administrative leave, staff termination)
For abuse incidents, please submit SIR follow-up report indicating action after investigation by Regional Center, Police and Licensing is completed.

Agencies Notified	Person Contacted	Date Telephoned	Date Report Submitted	Date of Visit
Regional Center	_____	_____	_____	_____
Licensing (CCL or DHS)	_____	_____	_____	_____
Police	_____	_____	_____	_____
CPS/APS/Ombudsman	_____	_____	_____	_____
Parent/Legal Guardian	_____	_____	_____	_____