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| INCIDENT REPORT | | | | | | | | | | | | | | | | | | | | | | | | | |
| STATE OF MICHIGAN  Michigan Department of Licensing and Regulatory Affairs  Child Care Licensing Bureau | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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(4)  Child Care Centers R 400.8158(4)  DISTRIBUTION  Send original to your licensing consultant and retain a copy for your records. | | | | | | | | | | | | | | | **Did you notify licensing via phone, email or fax?**  Note: Death of a child in care must be reported via phone. | | | | | | | | | | |
| Yes | | If yes, date and time?  Method of contact  Phone  Email  Fax  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| No | | If no, contact your licensing consultant within 24 hours of the incident. | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TYPE OF REPORT** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Incident** | | **Accident** | | | | | | | **Illness** | | | | | | | **Death** | | | | **Fire** | | | | | |
| **FACILITY** | | | | | | | | | | | | | | | | | | | | | | | | | |
| License Number | | | | | | | | Facility Phone Number | | | | | | | | | Facility Type | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | Family Child Care Home  Group Child Care Home  Child Care Center | | | | | | | | |
| Facility/Provider Name | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Address (Street Number and Name) | | | | | | | | | | | | County | | | | |
|  | | | | | | | | | | | |  | | | | |
| City | | | | | | | State | | | | | Zip Code | | | | |
|  | | | | | | |  | | | | |  | | | | |
| **CHILD(REN) IN CARE INVOLVED** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | | | Name | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | |
| Birthdate | | | Sex | | | | | | | | | | | Birthdate | | | | | Sex | | | | | | |
|  | | | M | | | F | | | | | | | |  | | | | | M | | | 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        A.M.  P.M. | | | | | | Location | | | | | | | | | | | | | | |
| Describe the incident. Be specific: | | | | | | | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Describe the incident (cont.): | | | | | | | |
| Was First Aid Given?  Yes  No  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** | | |
|  | | |  | |  | | A.M.  P.M. |
|  | | |  | |  | | A.M.  P.M. |
|  | | |  | |  | | A.M.  P.M. |
|  | | | | | | | |
|  | | | | | | | |
| Signature of Person Completing This Report | | Title | | | | Date | |
| Signature of Licensee/Responsible Person | | Title | | | | Date | |

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