

Kemper Services, Inc.

INCIDENT/ACCIDENT REPORT

Must be filed with Administrator within 24 hours of Accident/Incident

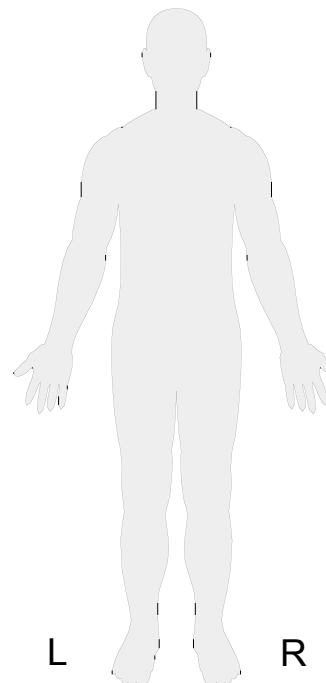
<i>Provider Name</i>	<i>List Name(s)/Phone(s)/Address(es) of Other Person(s) /Witness(es)</i>
<i>Phone</i>	
<i>Client Name</i>	
<i>Date&Time of Accident/Incident</i>	

Location/Full Address where Accident/Incident Occurred

Details of the Accident/Incident

Check and/or Circle All that Apply

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/>-Time ____ Administrator Contacted <input type="checkbox"/>-Medical/Emergency Evaluation Needed <input type="checkbox"/>-911 Contacted <ul style="list-style-type: none"> <input type="checkbox"/>-Police <input type="checkbox"/>-Fire <input type="checkbox"/>-Paramedic/EMT <input type="checkbox"/>-Death/Near Death Occurrence <input type="checkbox"/>-Weapon Observed/Used by _____ <input type="checkbox"/>-Type of Weapon _____ <input type="checkbox"/>-Rape/Molestation <input type="checkbox"/>-Violence/Battering <input type="checkbox"/>-Illness/Injury <input type="checkbox"/>-Stab Wound/Gun Shot Wound <input type="checkbox"/>-Cut/Gash/Scrape/Bloody <input type="checkbox"/>-Burn/Blister/Rash/Allergy <input type="checkbox"/>-Bruise/Sprain/Broken Bone <input type="checkbox"/>-Disease/Flu/Contagious Outbreak <input type="checkbox"/>-Food Poisoning/Vomiting/Diarrhea <input type="checkbox"/>-Body Fluid Contamination <ul style="list-style-type: none"> <input type="checkbox"/>-To/From Provider <input type="checkbox"/>-To/From Sibling <input type="checkbox"/>-To/From Client <input type="checkbox"/>-Infection/Red Streaks Noted <input type="checkbox"/>-Improper Handling of Biohazard <input type="checkbox"/>-Improper Infection Control Used <input type="checkbox"/>-Labored Breathing/Short of Breath <ul style="list-style-type: none"> <input type="checkbox"/>-CPR Administered <input type="checkbox"/>-Choking/Faint/Black Out <input type="checkbox"/>-Coughing/Asthma <input type="checkbox"/>-Chest Pain <input type="checkbox"/>-Respiratory Infection <input type="checkbox"/>-Drowning/Aspiration <input type="checkbox"/>-Allergic Reaction | <ul style="list-style-type: none"> <input type="checkbox"/>CPS Contact Necessary
Caseworker _____ <input type="checkbox"/>Client Abuse Suspected/Observed <ul style="list-style-type: none"> <input type="checkbox"/>-By Parent/Guardian <input type="checkbox"/>-Other _____ <input type="checkbox"/>-Psychological/Verbal Cruelty <input type="checkbox"/>-Animal Cruelty <input type="checkbox"/>-Physical Assault/Battery <input type="checkbox"/>-Public Health Hazard/Unsanitary <input type="checkbox"/>-Damage to House/Property <input type="checkbox"/>-Parent/Guardian Instability <input type="checkbox"/>Inconsistent Descriptions
tical Attention
it Loss/Gain <input type="checkbox"/>-Alcohol/Drug-Overdose/Abuse
Who? _____ <input type="checkbox"/>-Media Present (TV, RADIO)
Station(s) _____ <p style="text-align: center;">AUTO ACCIDENT</p> <ul style="list-style-type: none"> <input type="checkbox"/>-Vehicle(s)/Cycle Involved _____ Who? _____ |
|--|---|



PLEASE DOCUMENT
all affected areas on the above drawing

FULL DESCRIPTION

In your own words, please give a detailed description of the accident/incident, and a complete account of any witnesses or parties involved, using the back of this form if more space should be necessary.

I, _____, being of sound mind do certify that the above statements are true and accurate to the best of my ability this _____, day of _____, 20____.

Signed _____ Administrator _____