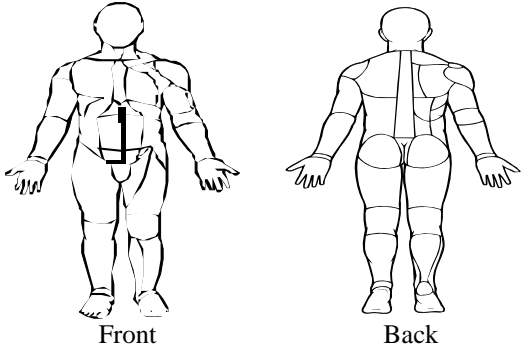


**COBB COUNTY COMMUNITY SERVICES BOARD  
DOUGLAS COUNTY COMMUNITY SERVICES BOARD**

**AGENCY INCIDENT REPORT**

**MUST BE COMPLETED BY EMPLOYEE WITHIN 24 HOURS OF INCIDENT**

Notify Clients Rights Representative immediately if there is a critical incident; #s page 2	
<b>Date of Incident:</b>	<b>Time of Incident:</b> <b>AM/PM</b>
<b>Circle location:</b>  <b>Residential:</b> MH        DD        AD  <b>Day Services:</b> MH        DD        AD        SE  <b>Outpatient:</b> COPS     DOPS     SE  <b>Inpatient Site:</b> SU        Hartmann  <b>Ancillary Site:</b> Administration  <b>Other:</b>	<b>Name of facility site/other locations where incident occurred, if applicable:</b>  <hr style="width:20%; margin-left:auto; margin-right:auto;"/> <b>Location of incident in facility site/other locations in the community:</b> <div style="background-color: #cccccc; height: 50px; width: 100%;"></div>
<b>Supervisor who was notified:</b>	
	<b>Date:</b> <b>Time:</b> <b>AM/PM</b>
<b>Check or write in the type of incident:</b>  <u>Left Services:</u> _____ <i>AMA</i> _____ <i>AWOL</i>  <u>Infections:</u> _____ <i>Infection/Contagious Disease</i>  <u>Damage:</u> _____ <i>Property</i> _____ <i>Vehicle</i>  <u>Injury:</u> _____ <i>Client</i> _____ <i>Staff</i> _____ <i>Visitor</i>  <u>Property Loss:</u> _____  <u>Seclusion and Restraint</u> _____  <u>Behavior</u> _____ <u>Other</u> _____	<b>Location of injury if applicable:</b>  <div style="text-align: center;">  <p style="margin-left: 100px;">Front</p> <p style="margin-left: 200px;">Back</p> </div> <p>Mark on the figures the general area of any cuts, scratches, marks or bruises possibly relating to the incident/accident.</p>
<b><u>Do not put medication errors on this form</u></b>	

**If more spaces are needed please write on the back of this page and/or on third page**

<b>Client or Staff Involved</b>	
Client Name:	CID #
<b>Involved Witnesses</b>	
Witness Name:	Witness Name:
Witness Name:	Witness Name:
<b>Employee(s) who witnessed incident</b>	
Staff Name:	Emp#
Staff Name:	Emp#
<b>Others</b>	
Name:	Name:
Name:	Name:
<b>Visitor</b>	
Visitor Name:	Address:
Phone number(s):	

Date of incident: \_\_\_\_\_  
Client: \_\_\_\_\_ CID \_\_\_\_\_

Staff: \_\_\_\_\_ Employee # \_\_\_\_\_

### Description of Incident

What did you see happened or what was reported to you?

Use page 3 if more space is needed

What actions did you take?

Use page 3 if more space is needed

Was there any need for debriefing after the incident?  
If so explain:

### Signature of Person Completing Report

Printed Name/Signature if legible \_\_\_\_\_

Title \_\_\_\_\_

Work site telephone no. \_\_\_\_\_ or cell phone no. \_\_\_\_\_

**Give original to Site Supervisor to review  
All originals should be sent to Adrienne Adams at Cobb Recovery Center through Interoffice Mail**

The Agency Incident Report and Critical Incident Report are to be sent to Adrienne Adams within **24 hours** during business hours.

**Fax #: 770-499-9328      Office #: 770-499-2422**

**All deaths must be reported to the Client Rights Representative within two hours.**

Date of Incident: \_\_\_\_\_

Client: \_\_\_\_\_ CID \_\_\_\_\_

Staff: \_\_\_\_\_ Employee # \_\_\_\_\_

**Summary and/or additional information if needed**

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**Signature of person writing summary**

**Date**

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**Signature of Client Rights Representative**

**Date**