INCIDENT FORM

DATE:		
FOSTER CARE PROVIDER:		
ADDRESS:		
TELEPHONE NUMBER:		
DATE OF INCIDENT:		
CHILD(REN) INVOLVED:		
WHERE DID INCIDENT HAPPEN:		
WHO ELSE WAS THERE:		
WHAT HAPPENED:		
MEDICAL TREATMENT REQUIRED:	☐ **YES**	☐ **NO**
IF YES, LIST DOCTOR AND/OR HOSPITAL, IF KNOWN:		
CHILD'S WORKER NOTIFIED?	☐ **YES**	☐ **NO**
WORKER'S NAME:		

Signature of Provider **Date**

*** Please return this form to Clay County Licensor within 24 hours of injury.**