Provider Name & Address:	
DODD – Possible or Determined MUI Report Form	
Individual's Name:	DOB:
Address:	City/County:
Date of Incident: Time of Incident: AM/PM	
Location of Incident (home in bathroom, at the mall, lunchroom at work):	
Description of Incident (Who, What, Where, When):	
Injury – Describe Type & Location:	
Immediate Action to Ensure Health & Welfare of Individuals:	
Name of PPI(s):	Relationship to Individual:
Witnesses to Incident:	Others Involved:

Type of Notification	Name/Title	Date/Time
Guardian / Advocate		
SSA (required for Independent Providers0		
Licensed or Certified Provider		
Staff or Family living at the Individual's home & responsible for the individual's care.		
LE (Name, Badge Number, Jurisdiction, and contact information required for Law Enforcement		
CPSA (Name and contact information required for Children Services)		
County Board		
Administrator (Required for ICF)		
Support Broker (If applicable)		

Additional Information/or Administrative Follow-Up:

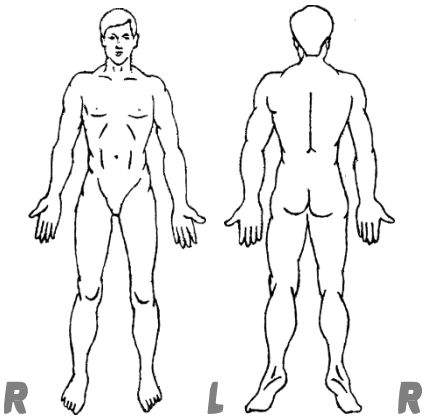
A. Further Medical Follow-up:

B. Administrative Action:

Signature: Title: Date:

Body Part Injured:

- O Head or Face
- O Mouth / Teeth
- O Hands / Arms
- O Feet / Legs
- O Other _____
- O Neck or Chest
- O Abdomen
- O Back / Buttocks
- O Genitals



Causes and Contributing Factors:

Preventive measures: (For Provider's internal use)

Administrator Review: _____ Date: _____