

# EARLY INTERVENTION REPORTABLE INCIDENT FORM

DATE OF REPORT:	TIME:  AM/PM
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Office of Child Development and Early Learning:  
Fax Number: 717-346-9330  
Phone Number: 717-265-8901

NAME OF INFANT OR TODDLER (LAST, FIRST, M.I.)			PROVIDER NAME:		
ADDRESS:			ADDRESS:		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
PHONE:		COUNTY OF REGISTRATION:	PHONE:		
INFANT OR TODDLER EIRS NUMBER:			BASE SERVICE UNIT NUMBER		
DATE OF BIRTH: M M    D D    Y Y Y Y -       -		SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED: M M        D D        Y Y Y Y -           -		
CLASSIFICATION OF INCIDENT:			TIME THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED:  AM/PM		
DESCRIBE THE TYPE OF INCIDENT AND THE ACTION(S) TAKEN TO ADDRESS THE INFANT/TODDLER'S HEALTH AND SAFETY AND THE RESPONSE TO THE INCIDENT, WHAT HAPPENED, IF A MEDICAL REFERRAL WAS NECESSARY (PLEASE LIST), DOCUMENT ALL OTHER REPORTS OR NOTIFICATIONS AND ANY CIRCUMSTANCES WHICH MAY HAVE PRECIPITATED THE INCIDENT: (INCLUDE ACTION TAKEN RELATED TO DISPOSITION OF EMPLOYEE.) ATTACH ADDITIONAL SHEETS IF NECESSARY.					
NAME OF PERSON RECEIVING REPORT:		TITLE:	PHONE:		