Office of Licensure
REPORTABLE INCIDENT FORM

Submit form to **TDMHSAS Office of Licensure**

Investigations Phone: 866-797-9470 Fax: 615-401-7644 Email: LicensureInv.fax@tn.gov

Report Date: _____	Reporting Person: _____
Agency Name: _____ (as listed on license)	Title: _____
Facility Phone #: _____	Contact #: _____
Agency Address: _____	Email Address: _____

Service Recipient: _____ Gender: ____ D.O.B: _____

Service Recipient: _____ Gender: ____ D.O.B: _____

Service Recipient: _____ Gender: ____ D.O.B: _____

Date and time of alleged/suspected incident: _____

Date and time incident became known to staff: _____

Location of alleged/suspected incident: _____

Staff-Patient ratio at time of incident if incident occurred in a residential facility: _____

(If allegation against staff, submit background check, abuse registry check, and sexual abuse registry check.)

Staff Name: _____ SS#: _____ DOB: _____

Staff Name: _____ SS#: _____ DOB: _____

Detailed Description of Incident: ☐ Check if additional page(s) attached.

_____

_____

_____

_____

_____

_____

_____

Notifications Already Made By Licensee:

☐ Adult Protective Services (APS) Name or Ref #: _____ Date: _____

☐ Child Protective Services (CPS) Name or Ref #: _____ Date: _____

☐ OTHER Agency: _____ Name or Ref #: _____ Date: _____

REPORTABLE INCIDENT FORM

Continued (if needed)

Report Date: _____ **Agency Name: _____**

(Please ensure font size is reader-friendly.)