



INCIDENT REPORT FORM

1. DYCD Providers must notify DYCD of Incidents via phone or e-mail within twenty four (24) hours of occurrence and submit a completed DYCD Incident Report Form via e-mail within three (3) days of occurrence to both of the following:
 - a. DYCD Program Manager (overseeing the contract to which the Incident relates) AND
 - b. incidentreports@dycd.nyc.gov
2. Providers enrolled in the City's Central Insurance Program must also fax the completed Incident Report Form to DYCD at (646) 343-6977.
3. Missing information must be provided in writing as soon as it is available. DYCD will return incomplete and unsigned Forms to the Provider for resubmission.
4. For Injury, Abuse or Other incidents, complete Section 1; in cases of Property Loss, complete Section 2.

Incident Report Completed By	
Name:	Date:
Title:	Email:
Work Address:	Phone:
Provider Information	
Agency Name:	Executive Director:
DYCD Program Information	
Program Area (SYEP, COMPASS, etc.):	DYCD Contract ID #:

SECTION 1 – INJURY, ABUSE & OTHER INCIDENTS

Incident Information		
Type of Incident: <input type="checkbox"/> Injury <input type="checkbox"/> Abuse/Maltreatment <input type="checkbox"/> Lost/Missing Child <input type="checkbox"/> Other:		
Date of Incident:	Time of Incident:	Occurred During Program Hours? <input type="checkbox"/> Yes <input type="checkbox"/> No
Incident Site Address:		
If Incident at a DOE Site, School Name and District & School Number:		
Name (of Person injured, abused, etc.):	Age:	Gender:
Status (of Person injured, abused, etc.): <input type="checkbox"/> Client/Participant <input type="checkbox"/> Guest <input type="checkbox"/> Staff <input type="checkbox"/> Other:		
Parent/Guardian Name (if a minor):		
Incident Description (Describe the incident in detail; continue on separate page if necessary)		

Other Persons Involved (indicate status: G=guest S=staff C=client W=witness O=other)

Name of Person	Age	Status	Nature of Involvement	Phone No.

Person Suspected of Causing Injury or Abuse (if applicable)

Name:	Parent/Guardian (if a minor):
Address:	Phone (if available):

Notifications Made (indicate all that apply)

Emergency Responder -or- Investigator	Date Called	Time Called	Responder Name -or- Person Taking Report	Badge -or- ID #	Comments
<input type="checkbox"/> NYPD					
<input type="checkbox"/> EMS					
<input type="checkbox"/> FDNY					
<input type="checkbox"/> NYC ACS					
<input type="checkbox"/> NYS SCR (800) 635-1522					
<input type="checkbox"/> NYS Justice Center					
Parent/Guardian Called: <input type="checkbox"/> Yes <input type="checkbox"/> No			If No, Why Not?		
If Yes, Time Called:			If Yes, Phone Number Called:		

Follow-up Actions (e.g. assistance, investigation, or policy review; if applicable, include whether any participants were expelled, suspended, or transferred; continue on separate page if necessary)

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Medical Treatment Received by Injured Person (if applicable):

Participant Returned to Program: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If Yes, Date of Return:

SECTION 2 – PROPERTY LOSS INCIDENTS**Type of Loss:** Lost Damaged Stolen

Item(s)	Description	Serial Number(s)	Value

Police Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date Notified:	Time:	Police Complaint #:
Responding Officer(s): Name _____	Shield # _____	Precinct # _____	
Name _____	Shield # _____	Precinct # _____	