## Monterey County Health Department Special and/or Unusual Incident Form

| Brief Description of Incident (time, place, circumstances)  Brief Description of Injuries, Property Damage, Fatalities  Brief Description of other(s) involved  Brief Description of other(s) involved  Names or Description of witness(es)  List of responding agencies  Publicity of Incident  Action(s) taken to maintain safety and security of work site  Action(s) Planned  Attachments  Report Submitted by (print and Sign):  Supervisor (Signature)  Division Chief (Signature)  Division Chief (Signature)  County use only:  HD Admin only: A copy of this report will be sent to and verbal notification was made to:  COONTY COUNSE  CAD/HR  Date/Time:  Name of Contact:  Department Head  Date/Time:  Name of Contact:  Department Head  Date/Time:  Name of Contact:  Department Head  Date/Time:  Name of Contact:  | Reporting Agency/Program and telephone number   | Name of Employee(s) Involved | Address/Location of Incident | Date of<br>Incident | Date of<br>Report |
|--|---|------------------------------|------------------------------|---------------------|-------------------|
| Brief Description of Injuries,   Property Damage, Fatalities   |   |                              |                              |                     |                   |
| Brief Description of Injuries,   Property Damage, Fatalities   | Brief Description of Incident   |                              |                              |                     |                   |
| Property Damage, Fatalities  Brief Description of other(s) involved  Names or Description of witness(es)  List of responding agencies  Publicity of Incident  Action(s) taken to maintain safety and security of work site  Action(s) Planned  Attachments  Report Submitted by (print and Sign):  Date:  Supervisor (Signature)  Division Chief (Signature)  Division Chief (Signature)  Date:  County use only:  HD Admin only: A copy of this report will be sent to and verbal notification was made to:  Caunty Counsel  CAO/HR  Date/Time:  Name of Contact:  Department Head  Date/Time:  Name of Contact:  Date/Time:  Name of Contact:  Department Head  Date/Time:  Name of Contact:  Name of Contact:  Date/Time:  Name of Contact:  Date/Time:  Name of Contact:  Date/Time:  Name of Contact:  Date/Time:  Name of Contact:  Name of Contact:  Date/Time:  Date/Time:  Name of Contact:  Date/Time:  | •   |                              |                              |                     |                   |
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| County use only:  HD Admin only: A copy of this report will be sent to and verbal notification was made to:  County Counsel Date/Time: Name of Contact:  CAO/HR Date/Time: Name of Contact:  Department Head Date/Time: Name of Contact:  Beta Healthcare Group Date/Time: Name of Contact   |   |                              |                              |                     |                   |
| County Counsel Date/Time: Name of Contact: CAO/HR Date/Time: Name of Contact: Department Head Date/Time: Name of Contact: Beta Healthcare Group Date/Time: Name of Contact   |   |                              |                              |                     |                   |
| CAO/HR Date/Time: Name of Contact: Department Head Date/Time: Name of Contact: Beta Healthcare Group Date/Time: Name of Contact  | HD Admin only: A copy of this report will be sent to and verbal notification was made to: |                              |                              |                     |                   |
| Department Head Date/Time: Name of Contact: Beta Healthcare Group Date/Time: Name of Contact   | County Counsel  | Date/Time:                   | Name of Conta                | act:                |                   |
| Beta Healthcare Group Date/Time: Name of Contact   | CAO/HR  | Date/Time:                   | Name of Conta                | act:                |                   |
| Beta Healthcare Group Date/Time: Name of Contact   | Department Head   | Date/Time:                   | Name of Conta                | act:                |                   |
| Director of Health (Signature) Date:   | Beta Healthcare Group   | Date/Time:                   | Name of Conta                | act                 |                   |
|  | Director of Health (Signature)  | )                            | Date:                        |                     |                   |

**CONFIDENTIAL Attorney/Client Privilege (When Completed)** 

## Monterey County Health Department Special and/or Unusual Incident Form

For Community Providers

| Reporting Agency/Program and telephone number                 | Name of Employee(s) Involved | Address/Location of Incident | Date of Incident | Date of<br>Report |
|---|------------------------------|------------------------------|------------------|-------------------|
|   |                              |                              |                  |                   |
| Brief Description of Incident (time, place, circumstances)    |                              |                              |                  |                   |
| Brief Description of Injuries,<br>Property Damage, Fatalities |                              |                              |                  |                   |
| Brief Description of other(s) involved                        |                              |                              |                  |                   |
| Names or Description of witness(es)                           |                              |                              |                  |                   |
| List of responding agencies                                   |                              |                              |                  |                   |
| Publicity of Incident   |                              |                              |                  |                   |
| Action(s) taken to maintain safety and security of work site  |                              |                              |                  |                   |
| Action(s) Planned   |                              |                              |                  |                   |
| Attachments   |                              |                              |                  |                   |
| Report Submitted by (print a                                  | nd Sign):                    | Date:                        |                  |                   |
| Supervisor (Signature)  |                              | Date:                        |                  |                   |
| Division Chief (Signature)                                    |                              | Date:                        |                  |                   |
| County use only:  |                              |                              |                  |                   |
| HD Admin only: A copy of                                      |                              |                              |                  | de to:            |
| County Counsel  | Date/Time:                   | Name of Con<br>Name of Con   |                  |                   |
| CAO/HR<br>Department Head                                     | Date/Time:<br>Date/Time:     | Name of Con<br>Name of Con   |                  |                   |
| Beta Healthcare Group   | Date/Time:<br>Date/Time:     | Name of Con                  |                  |                   |
| Director of Health (Signature                                 | •                            | Date:                        | .act             |                   |
| 111 1 111111 (019119000                                       | <i>'</i>                     |                              |                  |                   |



| Date |  |  |  |  |
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| 95<br>From:               |   |
|---------------------------|---|
| Program:                  |   |
| Phone:                    |   |
| Fax:                      |   |
| То:                       | <ul> <li>□ Mental Health Director's Office (831) 755-4980</li> <li>□ Quality Improvement Manager's Office (831) 831-755-4350</li> </ul> |
| Regarding                 | ; Special Incident Report   |
| 96<br>97 <b>Com</b><br>98 | ments:  |
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| Manag                     | he Critical Incident Stress gement (CISM Team) Contacted  |