HENNEPIN COUNTY
HUMAN SERVICES AND PUBLIC HEALTH DEPARTMENT
CHILD CARE / FOSTER CARE LICENSING
PROVIDER INCIDENT REPORT

Provider Name:  Provider Number:
Licensing Worker:  Date:
Child’s Social Worker:  Child’s Case Number:

Child Name:  Age:
Date of Incident:  Time of Day:  Location of Incident:

<table>
<thead>
<tr>
<th>Child's Social Worker</th>
<th>Name of Persons Notified</th>
<th>Name of Person Notifying</th>
<th>Date of Notification</th>
<th>Time of Notification</th>
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<tbody>
<tr>
<td>Licensing Social Worker</td>
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<tr>
<td>Other</td>
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Description of Incident (include extent of injury, if applicable): [If needed, attach separate sheet.]

Action Taken / Resolution: [If needed, attach separate sheet.]

SIGNATURES:

Foster Parent / Child Care Provider:  Date:  
Licensing Social Worker:  Date:  
Supervisor:  Date:  

Original: Provider File – Medical Section
Copy: Child’s CF File – Placement Section
Copy: Foster Parent