NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DETENTION SERVICES UNUSUAL INCIDENT REPORT

<table>
<thead>
<tr>
<th>NAME OF DETENTION FACILITY:</th>
<th>FACILITY CODE #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF YOUTH:</td>
<td>DOB:</td>
</tr>
<tr>
<td>NAMES OF OTHERS INVOLVED (Indicate staff(S) or your (Y):</td>
<td></td>
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<tr>
<td>NAMES OF WITNESSES (Indicate staff(S) or your (Y):</td>
<td></td>
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</tbody>
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<tr>
<th>DATE OF INCIDENT:</th>
<th>TIME: (Check One)</th>
<th>AM</th>
<th>PM</th>
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</thead>
</table>

INCIDENT TYPE: (Check all that apply)
- □ birth
- □ assault on staff
- □ assault on youth
- □ child abuse allegation*
- □ fire *
- □ suicide attempt

*These incidents must be verbally reported immediately to OCFS.

Describe incident and circumstances surrounding it – include location, early warning signals, names of direct care staff on duty and their location at the time of incident. (attach additional pages if necessary).

Was the incident reported to the State Central Register (SCR)?
- □ Yes
- □ No

If reported to the SCR, was a number assigned? If yes, please provide the number # (SCR)
- □ Yes
- □ No

Was the incident verbally reported to OCFS?
- □ Yes
- □ No

If so, by whom? , Title

Was a restraint used?
- □ Yes
- □ No
If so, Indicate which.
- □ Physical
- □ Mechanical
- □ Medical

If yes, attach narrative report including approving authority.

Was anyone injured?
- □ Yes
- □ No

Was anyone injured?
- □ Yes
- □ No

NAMES OF THOSE INJURED: (Indicate youth (Y) or staff (S):

<table>
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</table>
Describe injuries precisely:

Describe medical attention provided. (Include date, time, location):

Describe any follow-up, if applicable:

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<tr>
<th>ATTACH ADDITIONAL SHEETS AS NEEDED</th>
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</thead>
<tbody>
<tr>
<td>NAME OF PERSON FILLING OUT THE REPORT:</td>
</tr>
<tr>
<td>SIGNATURE OF PERSON FILLING OUT THE REPORT:</td>
</tr>
<tr>
<td>TITLE:</td>
</tr>
</tbody>
</table>

| SIGNATURE OF FACILITY DIRECTOR/ADMINISTRATOR: | DATE: |