Ashtabula County Board of Developmental Disabilities

_____ _____ _____

(year) (Qtr./Semi-Annual/Annual) (UI or MUI)

Incident Review Verification

The purpose of this form is to provide verification that INCIDENT TRACKING reports have been reviewed for trends, patterns, or other concerns and that appropriate actions were taken when necessary. Please complete this form, including any corrective action, and return to:

MAIL TO:
Ashtabula County Board of DD
Attn: ISS Department
2505 South Ridge East
Ashtabula, OH 44004

or

FAX TO:
(440) 224-0678

or

EMAIL TO:
pamela.rose@ashtabuladd.org

SEND:
Send via ACBDD bus, if available.

PROVIDER NAME: ___

(Check appropriate category below):

☐ **Reviewed _____ incident logs. No trends, patterns, or corrective action needed.**

☐ **Reviewed _____ incident logs. Identified trends/patterns and/or corrective action. See below explanation (add additional sheets if necessary):**

(Explain trend or pattern discovered): ___

___ ___ ___

Provider Signature **Title** **Date**

CB Received: _____ IA Reviewing Report: _____ Follow Up w/ Provider needed: NO / YES