Ashtabula County Board of Developmental Disabilities

_____ UI / MUI Year: _____

(Fill in first quarter, semi-annual, third Quarter, or Annual) (circle)

# 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):

_____

_____

_____

_____

_____

_____

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_____

_____

_____

Provider Signature Title Date

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