



Non-Critical Incident Report

*Please complete the report for any incident that occurs during normal day-to-day operations and requires an intervention by staff.
This report shall be forwarded to the Community Supervision Agency Officer.*

Youth's Name:

Date of Incident:

Time of Incident:

Location of Incident:

Description of Incident

Was the youth injured during the incident?

Yes

No

Was a staff member injured during the incident

Yes

No

Action Taken / Intervention

(please select all types that apply to this incident)

Intervention Type #1:

Intervention Type #2:

Intervention Type #3:

Intervention Type #4:

Date DCF Notified:

DCF Incident Number:

(if an intervention type of "Other" or "Cognitive Behavioral Tool" was selected please state the specific type in the comments field)

Comments

Name of Staff Completing this form:

Date form was completed:

Date officer notified:

Method of notification (i.e., e-mail, phone, fax):