

Virginia Department of Health  
**Office of Licensure and Certification**

3600 West Broad Street, Suite 216  
Richmond, Virginia 23230

Phone: 804/367.2122

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**Facility Reported Incident (FRI)**

*Use of this form is optional*

*Reporting as required is not optional.*

*Failure to provide credible protective/preventive measures at the time of an initial report or failure to provide evidence of a thorough investigation with corrective measures in the final report may result in VDH conducting an on-site investigation to determine if acceptable practices are in place to protect residents.*

**Facility Name:** \_\_\_\_\_

**Report date:** \_\_\_\_\_ **Incident date:** \_\_\_\_\_

**Residents involved:** \_\_\_\_\_

Injuries:  Yes  No If yes, describe:

**Incident type:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allegation of abuse/mistreat      | <input type="checkbox"/> Injury of unknown origin  | <input type="checkbox"/> Life/safety affected |
| <input type="checkbox"/> Allegation of neglect             | <input type="checkbox"/> Resident Elopement  | <input type="checkbox"/> Utility failure      |
| <input type="checkbox"/> Resident property misappropriated | <input type="checkbox"/> Communicable disease (notify local health department pursuant to 12 VAC 5-90) | <input type="checkbox"/> Fire                 |
| <input type="checkbox"/> Suspicious death                  |  | <input type="checkbox"/> Structural damage    |

**Describe incident, including location, and action taken:**

**Name of employee(s) involved and their positions:**

**Employee action initiated or taken:**

**If applicable, date notification provided to:**

- Responsible party \_\_\_\_\_
- Physician \_\_\_\_\_
- APS \_\_\_\_\_
- DHP \_\_\_\_\_
- Law Enforcement \_\_\_\_\_

**Facility internal investigation:**

Completed on: \_\_\_\_\_ Is attached:  Yes  No

Will be conducted/Report forward to VDH/OLC: \_\_\_\_\_

*For 5-working day and final reports, include a summary of the investigation and corrective measures implemented to prevent recurrence.*

Revised 10-2006

Name & Title of Reporting Person: \_\_\_\_\_