



EFMP RESPITE CARE
MEDICAL INCIDENT REPORT

For serious incidents or injuries, providers must complete and submit a copy to their EFMP Respite Care POC within 12 hours.

Family: _____ ID#: _____ Provider: _____ ID#: _____

Date: _____ Time: _____ AM/PM

Description of incident/injury: _____

Action taken:

- | | | |
|--|---|-------------------------------------|
| ☐ Notified parent | ☐ Rest/observation | ☐ Called EMS |
| ☐ Iced for ____ minutes | ☐ _____ | ☐ _____ |

Provider signature

Parent signature

EFMP Respite Care POC must submit a copy to CCAoA within one business day of receipt.

Date Received by Partner Agency: _____

Name of Partner Agency Staff: _____

Action taken:

- | | |
|--|--|
| ☐ Follow up with Family | ☐ Follow up with Provider |
|--|--|

Notes: _____

CCAoA must submit a copy to the Service Branch Headquarters within one business day of receipt.

Date Received: _____

Confirmation of Family Region / State: _____

Name of CCAoA Staff: _____