

Program Level Event

<b>Event ID:</b>	
<b>Date of Event:</b>	<b>Time of Event:</b>
<b>Program/Facility:</b>	
<b>Category of Event:</b>	<b>Sub-Category:</b>
<b>Specify:</b>	
<b>Synopsis of Event:</b>	

**Incident Information**

**Incident Information**

<b>Location of Incident:</b>	<b>Specify:</b>
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**Description of Incident:**

**Was the UAC or Anyone Else Injured? (If Yes, SIR must be created)**       Yes  No

**Specify:**

<b>Internal Investigation?:</b> <input type="radio"/> Yes <input type="radio"/> No	<b>Date Investigation Completed:</b>
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**Results/Findings of Investigation:**

**Actions Taken**

**Was the UAC or Anyone Else Evacuated?**       Yes  No

**Specify:**

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to allow ORR care provider programs to inform ORR of events may affect the entire care provider facility, such as an active shooter or natural disaster. Public reporting burden for this collection of information is estimated to average 0.333 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information (Homeland Security Act, 6 U.S.C. 279). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. If you have any comments on this collection of information please contact UCPolicy@acf.hhs.gov.

**Staff Response  
and  
Intervention:  
Follow-up and/or  
Resolution:**

**Reporting**

**State Licensing**

**Reported to State Licensing:**  Yes  No  N/A

**Date of Report:**

**Time of Report:**

**Was the Incident Investigated?**  Yes  No  N/A

**Date Notified the Investigation will be Investigated:**

**Case/Confirmation Number:**

**Specify:**

**Results/Findings of Investigation:**

**Law Enforcement**

**Reported to Law Enforcement:**  Yes  No  N/A

**Date of Report:**

**Time of Report:**

**Was the Incident Investigated?**  Yes  No  N/A

**Date Notified the Investigation will be Investigated:**

**Case/Confirmation Number:**

**Specify:**

**Results/Findings of Investigation:**

**ORR Notifications**

<b>Name</b>	<b>Agency/Title</b>	<b>Date Notified</b>	<b>Time Notified</b>	<b>Email</b>	<b>Telephone number</b>
	ORR/FFS				
	ORR/PO				
	ORR Intakes				
	Medical Coordinator				
	Case Coordinator				
	CFS				
	SIR Hotline				

**Reporter and Follow-Up Contact**

<b>Type</b>	<b>Name</b>	<b>Title</b>	<b>Email</b>	<b>Telephone number</b>
Staff Filing Report				
Contact for Follow-Up				