Program Level Event

Event ID:			
Date of Event:		**Time of Event:**	
Program/Facility:			
Category of Event:		**Sub-Category:**	
Specify:			
Synopsis of Event:			

Incident Information

Incident Information

Location of Incident:		**Specify:**	
Description of Incident:			
Was the UAC or Anyone Else Injured? (If Yes, SIR must be created)	○ Yes ◉ No		
Specify:			
Internal Investigation?:	○ Yes ◉ No	**Date Investigation Completed:**	
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

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

Reporter and Follow-Up Contact

Type	Name	Title	Email	Telephone number
Staff Filling Report				
Contact for Follow-Up				