

Health Care Personnel Registry
24-HOUR INITIAL REPORT
Allegation Report by Facility/Provider

All allegations against health care personnel, including injuries of unknown source which appear to be related to resident abuse or neglect, must be reported to the HCPR within 24-hours. [see NC Gen. Stat. §131E-256(g)]

Certain providers must report a reasonable suspicion of a crime with resulting serious bodily injury within 2-hours, and a reasonable suspicion of a crime without resulting serious bodily injury within 24-hours. [see 42 U.S.C. 1320b-25]

Provider Information		County: _____	Facility/ Provider Type: _____
Facility/Provider Name: _____			
Facility/Provider License #: _____	National Provider #: _____	Other ID #: _____	
Main Office Phone #: () _____	Main Office Fax #: () _____	Email Address: _____	
Contact Person: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. _____	Title: _____		
Administrator: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. _____	Title: _____		
MAIN OFFICE			
Mailing Address: _____		City: _____	State: _____ Zip: _____
ACTUAL INCIDENT			
Location Address: _____		City: _____	State: _____ Zip: _____

Allegation/Incident Type <i>(check all that apply)</i>	<input type="checkbox"/> REASONABLE SUSPICION OF A CRIME <i>(Explain under "Allegation/Incident Details" below)</i>	Is reasonable suspicion of a crime related to any allegation checked below? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> ① RESIDENT ABUSE	<input type="checkbox"/> ④ DIVERSION OF FACILITY DRUGS	<input type="checkbox"/> ⑦ MISAPPROPRIATION OF FACILITY PROPERTY
<input type="checkbox"/> ② RESIDENT NEGLECT	<input type="checkbox"/> ⑤ FRAUD AGAINST RESIDENT	<input type="checkbox"/> ⑧ MISAPPROPRIATION OF RESIDENT PROPERTY
<input type="checkbox"/> ③ DIVERSION OF RESIDENT DRUGS	<input type="checkbox"/> ⑥ FRAUD AGAINST FACILITY	<input type="checkbox"/> ⑨ INJURY OF UNKNOWN SOURCE

Allegation Description	Incident Date: _____	Time: _____	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Description of Physical or Mental Injury/Harm: _____			

Resident Information	Resident Full Name: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. _____	Date of Birth: _____
Resident's Type of Care/ Service & Setting: _____ <i>(Examples - Home Care, Nursing Home, Hospital/Acute Care, Day Program, CAP, CBS, Substance Abuse, Respite, etc.)</i>		

Accused Individual Information	Full Name: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. _____
Job Title: _____	Date of Hire: _____ Date of Birth: _____
Social Security # (required): _____	Taxpayer ID # or other ID #: _____
Last Known Address: _____	City: _____ State: _____ Zip: _____
Home Phone #: () _____	Other Phone # (Cell phone, work, etc.): () _____

Law Enforcement	Is there a Reasonable Suspicion of a Crime? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there Serious Bodily Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Incident reported to law enforcement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date reported: _____	Time Reported: _____
Name of law enforcement agency: _____		
Investigating Officer: _____		Phone #: () _____

▶ INVESTIGATION REPORT MUST FOLLOW WITHIN 5 WORKING DAYS ◀
The results of all investigations must be reported within five working days of the initial notification to the department. [see NC Gen. Stat. § 131E-256.(g)]
Failure to comply may result in a report to the agency having jurisdiction for compliance enforcement.

_____ <i>(Print Name and Title of Person Preparing Report)</i>	_____ <i>(Signature of Person Preparing Report)</i>	_____ <i>(Date Signed)</i>
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