



UTAH DEPARTMENT OF HEALTH

UTAH DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH AND PREPAREDNESS
BUREAU OF HEALTH FACILITY LICENSING AND CERTIFICATION

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(801) 274-0658 Fax
HealthFacilityComplaint@utah.gov

INITIAL ENTITY REPORT

REPORTING INDIVIDUAL [text box]

EMAIL ADDRESS [text box] PHONE NUMBER [text box]

FACILITY NAME [text box] ADDRESS [text box]

TYPE OF REPORT

[checkbox] RESIDENT TO RESIDENT [checkbox] STAFF TO RESIDENT [checkbox] UNKNOWN INJURY [checkbox] MISAPPROPRIATION [checkbox] ELOPEMENT

OTHER [text box]

INDIVIDUAL(S) INVOLVED

RESIDENT(S) INVOLVED [text box]

STAFF INVOLVED & POSITION [text box]

ALLEGED PERPETRATOR & RELATIONSHIP TO RESIDENT [text box]

OTHERS CONTACTED

(Please select all that apply)

[checkbox] APS CASE NUMBER [text box] DATE REPORTED [text box] [checkbox] OMBUDSMAN [checkbox] FAMILY
[checkbox] POLICE CASE NUMBER [text box] DATE REPORTED [text box] [checkbox] PHYSICIAN

INCIDENT

DATE OF INCIDENT [text box] TIME OF INCIDENT [text box]

WHAT OCCURRED

[Large empty text box for incident description]

WHAT ACTION HAS THE FACILITY TAKEN? (Suspension, Moved, Terminated, Etc)

[text box for facility action]