KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

# RISK MANAGEMENT REPORT FORM

(Please attach additional sheets as needed)

Reporting Party: Name_____
Last First M. I. Position

Facility Name: _____ Phone No.:_____
Please use no abbreviations for facility name

Address: _____ E-mail address:_____
(Street/PO Box) (City) (Zip Code)

## Reportable Incident Information

Incident # _____ Date of Incident: _____ MM/DD/YYYY

Provider ID: _____
(Name & Certification number if applicable) certification #

Facts of the Incident (Description, date etc.):

Standard of Care (SOC) Determination: _____ Conclusion/Rationale for the SOC determination:

Actions taken:

Recommendations for Minimizing Future Occurrences:

**Return this report to:**

**Risk Management Program**
Bureau of Community Health Systems
Health Facilities Program
1000 SW Jackson Street, Suite 330
Topeka, Kansas 66612-1365
(785) 296-4714-Telephone
(785) 291-3419-Fax
jsengstacken@kdheks.gov