

NEW YORK STATE COMMISSION OF CORRECTION

**REPORTABLE INCIDENT FORM**

NAME AND TITLE OF REPORTING PERSON: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

DATE OF INCIDENT: \_\_\_\_\_ TIME: \_\_\_\_\_

DATE REPORTED: \_\_\_\_\_ TIME: \_\_\_\_\_

LOCATION OF INCIDENT: \_\_\_\_\_

PERSON(S) INVOLVED: \_\_\_\_\_

DATE OF BIRTH(S): \_\_\_\_\_

**BRIEF SUMMARY OF INCIDENT**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE (FOR SCOC STAFF ONLY)**

DATE REPORT RECEIVED: \_\_\_\_\_

SCOC STAFF NAME: \_\_\_\_\_

REFERRALS: YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, WHERE? \_\_\_\_\_

SCOC CONTROL NUMBER: \_\_\_\_\_