



# SHEBOYGAN COUNTY

Division of Public Health  
Health and Human Services Department



Public Health  
Sheboygan County  
Division of Public Health

## DEATH, INJURY, AND ILLNESS REPORT

ATCP 72

The licensed establishment shall report incidents resulting in serious injury, illness, or death, where an emergency medical service response is required, by the end of the next working day following the incident, by phone or email to the department or its agent. Completion of this form is recommended to meet reporting requirements. Failure to report incidents is subject to compliance action under Admin. Code ch. ATCP 72. Personally identifiable information you provide may be used for purposes other than that for which it was collected. Wis. Stat. § 15.04 (1)(m).

Report only those injuries or illnesses that require assistance from EMS response or if there is a suspected/confirmed outbreak.

ESTABLISHMENT AND LICENSEE INFORMATION			
ESTABLISHMENT NAME	CONTACT PERSON		BUSINESS PHONE: ( ) -
ESTABLISHMENT ADDRESS STREET:	CITY:	STATE:	ZIP:
EMAIL ADDRESS:	PHONE NUMBER: ( ) -		
MAILING ADDRESS STREET (if different):	CITY:	STATE:	ZIP:

AFFECTED PARTY INFORMATION					
LAST NAME OF INJURED PARTY:	FIRST NAME:	MIDDLE:	D.O.B. (mm/dd/yyyy):	NUMBER OF INDIVIDUALS AFFECTED:	
ADDRESS:	CITY:	STATE:	ZIP:	PHONE NUMBER: ( ) -	
NAME OF PARENT/GUARDIAN (IF MINOR):			PHONE NUMBER: ( ) -		
ADDRESS:	CITY:	STATE:	ZIP:		

INCIDENT INFORMATION						
TYPE OF INJURY:	<input type="checkbox"/> Injury	<input type="checkbox"/> Death	<input type="checkbox"/> Illness	<input type="checkbox"/> Suspected Outbreak	<input type="checkbox"/> Confirmed outbreak	
DATE OF INCIDENT:	DAY OF WEEK:	DAY:	MONTH:	YEAR:	TIME:	

**Detailed description of incident** (describe the sequence of activity in detail, including what the injured person was doing at the time of the incident and location on the premises and where incident occurred. If it was associated with an outbreak, identify the potential cause):

Check applicable immediate treatment provided prior to ambulance arrival:	<input type="checkbox"/> AED	<input type="checkbox"/> First Aid	<input type="checkbox"/> CPR
Who completed the treatment:			

FORM SUBMISSION INFORMATION			
FIRST AND LAST NAME OF INDIVIDUAL SUBMITTING REPORT:	POSITION/ASSOCIATION::	PHONE NUMBER: ( ) -	DATE:

Email the completed form to [environmental.health@sheboygancounty.com](mailto:environmental.health@sheboygancounty.com)

**STOP**

**AGENT HEALTH DEPARTMENT OR DATCP FIELD SANITARIAN USE ONLY**

INSPECTOR NAME:	TITLE: ENVIRONMENTAL HEALTH SANIARIAN
AGENCY: SHEBOYGAN COUNTY DIVISION OF PUBLIC HEALTH	DATE:
EMAIL ADDRESS:	PHONE NUMBER:
COMMENTS:	
OFFICIAL'S SIGNATURE:	PRINTED NAME:
LICENSE CATEGORY:	
Agent or DATCP Sanitarian – Please submit documents by email to: <a href="mailto:DATCPDFRSRetail@wi.gov">DATCPDFRSRetail@wi.gov</a> (for a food facility) <a href="mailto:DATCPDFRSRec@wi.gov">DATCPDFRSRec@wi.gov</a> (for a recreational facility)	Mail to: DATCP – DFRS Attn: Technical Section PO Box 8911 Madison, WI 53708-8911