Monthly Incident Reporting

Provider Name: _____

Month: _____

Number of Incidents involving NTBHA Consumers: _____
(Please report numbers for all clinic locations combined)

I have verified that all incident reports for this month have been submitted to QM@NTBHA.org. ___ Yes ___ No

Signature: _____

Title: _____

Date: _____

By signing this form, you are attesting to the above information being accurate

Submit this form to QM@NTBHA.org by the 5th business day of the month