State of Illinois
Department of Human Services

RESTAURANT MEALS PROGRAM INCIDENT REPORT

Date and Time of Incident:

Restaurant Name:

Restaurant Address:

Description of Incident:

Action Taken or Response to Incident:

Person(s) Involved in the Incident:

Was anyone injured? Yes ☐ **No** ☐ **Describe Injury:**

Name of Person Preparing Report:

Witness Yes ☐ **No** ☐

Name of Witness: **Phone Number:**

Printed Name and Signature of Individual Completing Form: **Date:**

This form must be sent within 72 hours from the time of incident to (EMAIL PREFERRED):
ILLINOIS DEPARTMENT OF HUMAN SERVICES
STATEWIDE PROGRAM INITIATIVES/EBT
100 SOUTH GRAND AVE. EAST
SPRINGFIELD, IL 62703
EMAIL: DHS.LINK@ILLINOIS.GOV SUBJECT LINE: INCIDENT REPORT