HACAP
Incident Employee Report

Name: ___________________________________

Incident Address: __________________________

Date of Injury: __________

Time: _________ a.m. p.m.

Date Reported: __________

Witnesses: _________________________________

Incident Description:

Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head 2 ☐ Eye: L / R 3 ☐ Shoulder L / R 4 ☐ Arm L / R 5 ☐ Elbow L / R 6 ☐ Wrist L / R 7 ☐ Hand L / R 8 ☐ Finger: Specify ____________ 9 ☐ Back 10 ☐ Chest 11 ☐ Abdomen 12 ☐ Pelvis 13 ☐ Hip L / R 14 ☐ Leg L / R 15 ☐ Knee L / R 16 ☐ Ankle L / R 17 ☐ Foot L / R 18 ☐ Toe: Specify ____________ 19 ☐ Other: ______ ____________	 LEFT RIGHT	1 ☐ Abrasion 2 ☐ Amputation 3 ☐ Bite: ________ 4 ☐ Bruise 5 ☐ Burn 6 ☐ Concussion 7 ☐ Cut / Laceration 8 ☐ Foreign Body 9 ☐ Fracture 10 ☐ Hearing Impaired 11 ☐ Infection 12 ☐ Pain: ________ ____________ 13 ☐ Puncture 14 ☐ Rash/Dermatitis 15 ☐ Respiratory 16 ☐ Strain/Sprain 17 ☐ Other: ______ ____________

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Have you ever injured this body part before? YES NO if so, when? ______________________

Are you currently receiving medical treatment for the prior injury? ________________________________

Initial treatment *(check one)*:

___ No medical treatment

___ Minor/on-site treatment

___ Walk-in Clinic/Hospital

___ Emergency care

___ Hospitalization

Initial medical provider's name:
____

Address of medical provider:
____

Were proper procedures being followed when the incident occurred?

____ Yes ____ No

If no explain:

Were you wearing proper personal protective equipment?

____ N/A ____ Yes ____ No

If no explain:

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What ideas do you have for remedying the situation?

Are changes in equipment necessary to prevent reoccurrence?

____ Yes ____ No

If yes explain:

Is there any other information you feel is relevant to this situation?

Date form completed ______________________

Time completed _________________________

Notify Human Resources as soon as possible.

*Original sent inter-office mail, email to HResources@hacap.org *