HACAP
Management Incident Report

Employee	Dept.	Job Title
Date of Incident Time AM or PM		
Address of Incident		
Date Reported / / Time Reported	Reported to Whom?	
NAME OF WITNESS		
(1)		
(2)		
What was employee doing when injured? BE SPECIFIC		
How did the injury/illness occur?		
Was employee performing function alone? ☐ Yes ☐ No What employee was assisting with the operations?		
Did injury occur because of: Failure to follow safety rules ☐ Failure to use safety device ☐ Other ☐		
How long has employee been doing this job? (days, months, years)		
What safety equipment is required on the job the employee was performing?		
Was the employee using all required safety equipment? Yes ☐ No ☐		
If No, which specific personal protective equipment was not used & why?		
Does an unsafe condition exist that contributed to the cause, if so, what is that condition?		

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

RECOMMENDED ACTION			Person Responsible	Assigned Date	Completed Date
Re-instruction	Yes☐	No☐			
Equipment repair/replacement	Yes☐	No☐			
Reduce Clutter	Yes☐	No☐			
Improve Design/construction	Yes☐	No☐			
Workstation Modification	Yes☐	No☐			
Discipline of person(s) involved	Yes☐	No☐			
Other					

Date form completed _____

Time completed _____

Signature _____

Notify Human Resources as soon as possible.

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