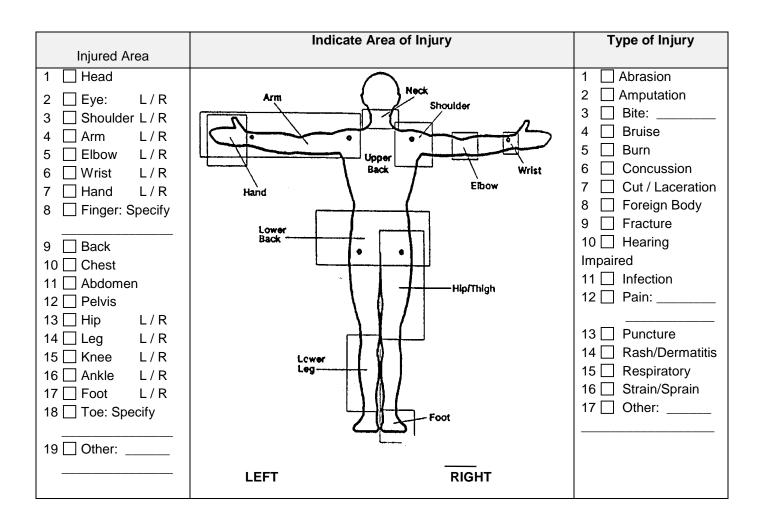
HACAP Incident Employee Report

Name:			 	_
Incident Addres				
Date of Injury:				
Time:	_ a.m.	p.m.		
Date Reported:				
Witnesses:			 	
Incident Descrip	otion:			



HACAP Incident Employee Report

Have you ever injured this body part before?	YES	NO	if so, when?
Are you currently receiving medical treatment f	for the pri	or 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 foll	lowed wh	nen the in	cident occurred?
Yes No			
If no explain:			
Were you wearing proper persona	al protecti	ive equipi	ment?
N/A Yes No			
If no explain:			

HACAP Incident Employee Report

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 *				