HPA Healthcare

Incident Report Form

Employee Information

1. **Employee Name**: _____
2. **Incident Location**: _____
3. **Date of Accident**: _____
4. **Time of Incident**: _____
5. **Date of Report**: _____
6. **Time of Report**: _____

Accident Details

7. **Description of Accident**:

_____

_____

8. **Description of the Injured Body Part** (include Left/Right):

_____

_____

9. **Were there witnesses?** (Y/N): _____
   If Y, please explain:

_____

_____

10. **Was there a safety device in use?** (Y/N): _____
    If Y, please describe:

_____

_____

Medical & Treatment Information

11. **Is Clinician following standard facility incident reporting and treatment process for full-time staff?** (Y/N): _____

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12. **Is the employee seeking medical treatment?** (Y/N): _____
13. **Treating Facility Name & Address**:

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14. **Do you have knowledge of any pre-existing conditions, prior accidents, or current medical treatment which may have been a contributing factor in the incident/injury?** (Y/N): _____
    If Y, please explain:

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15. **Will the employee miss work beyond the date of the accident?** (Y/N): _____
    If Y, last date worked:

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16. **Modified or Light Duty Available?** (Y/N): _____

Supervisor Information

17. **Supervisor Name**: _____
18. **Supervisor Email Address**: _____

Report Details

19. **Name of Person Reporting Incident**: _____
20. **Your Email Address**: _____
21. **Your Phone Number**: _____
22. **Message**:
