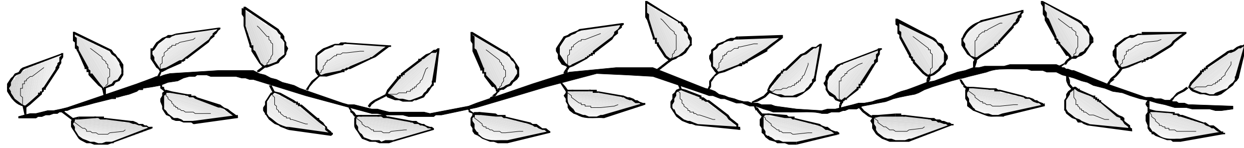

Hawaii Behavioral Health

210 Ward Avenue, Suite 124
Honolulu, Hawai'i 96814

Telephone: (808) 585-1424
Fax: (808) 585-0379

Hawaii Behavioral Health

EMPLOYEE INCIDENT REPORT

Employee: ___________________________________ Date of Birth: ____________

Address: _______________________________ City: _______________ State: ____

Telephone Number: ______________________

Position/Title: ____

Date of Incident: ________________ Time: ______________ AM / PM

Employee Completing Report: ___________________________________

Location of Incident: ____

Injury Occurred?: Yes _____ No _____
Medical Treatment Sought?: Yes _____ No _____

Describe Injury:

____
____
____

Name of Medical Facility or Physician Seen: ___________________________________

Police Notified: Yes _____ No _____

Other person(s) involved (give initials and/or title such as staff, teacher participant, etc.)

____

Witnesses (if any): ______________________
Telephone No.: ______________

Type of Incident:
- ☐ Injury
- ☐ Property Damage
- ☐ Equipment Malfunction
- ☐ Trespassing
- ☐ Medication Error
- ☐ Theft/Loss
- ☐ Vehicle Damage
- ☐ Fire
- ☐ Threat

Cause of Incident:
- ☐ Faulty Equipment
- ☐ Medical/Physical Condition
- ☐ Unknown
- ☐ Accident
- ☐ Substance Abuse
- ☐ Other: ______________________

____

Describe incident as occurred or found:

____

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Employee Signature: ________________________________ Date: ______________

Printed Name: ________________________________

Executive Director Signature: ________________________ Date: ______________