

XYZ HHA
Liability Incident Report

1. Patient Name: _____

2. Patient Address: _____

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3. Property Address (If Different): _____

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4. Date of Incident Being Reported: _____

5. Name of Injured Party / Potential Claimant: _____

6. Address of Injured Party / Potential Claimant: _____

7. Phone Number of Injured Party / Potential Claimant: (_____) _____

8. Description of Incident: _____

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9. Was the Police/Fire Department Called? _____

If 'Yes', Please Attach a Copy of Report From Responding Public Service Agency?

10. Which County/Municipality/State Public Service (Police, Fire, Emergency) Responded? _____

11. How and When Were You First Notified of This Incident?: _____

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12. Was There Any Other Responsible Party Involved?: _____

13. If "Yes", Explain The Nature of Involvement of Other Party: _____

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Incident Report Form (Liability)

Page Two of Two

14. List Damages and Amounts or Injuries, Along with the Source That You Received This Information From: _____

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15. Do You Have Any Reason to Believe That the Potential Claimant Will Pursue a Claim Against You? _____

If So, Why? _____

16. Has the Potential Claimant Indicated Their Intention to File a Claim Against You? _____

17. Has the Potential Claimant Already Made a Claim Against You? _____

18. If "Yes" on Either Question, Please List Name, Address and Phone Number of Claimant's Attorney: _____

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19. Were Any Witnesses Present to the Alleged Incident?: _____

If So, Did Any Provide a Statement Following the Incident?: _____

20. Please List the Name(s) and Address(es) of all Witnesses to the Incident:

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This Form Has Been Completed By:

Name (Please Print): _____

Address: _____

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Telephone Number: (_____) _____

Signature: _____
