





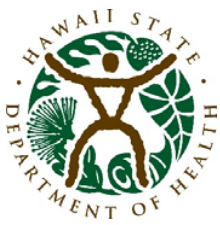
# Office of Health Care Assurance

601 Kamokila Blvd., Room 395

Kapolei, Hawaii 96707

Phone: (808) 692-7420 | Fax: (808) 692-7447

Incident Outcome and Notifications:		
Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe the injury:		
Treatment required: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list type of treatment provided and where the treatment was provided:		
Physician notified: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of notification:	Responsible party notified: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Notification:	
Police notified: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Notification:	Administrator notified: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Notification:	
Other agencies involved: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list other agencies involved:		
Perpetrator (Staff)		
Ejor r gvg. 'kf the Alleged Perpetrator is a staff member:		
Name:		Position/Title:
License/Certificate #:	License/Certificate Expiration Date:	Phone number where staff member can be reached:
Current Address:		
City:	State:	Zip Code:
Perpetrator (Non-staff)		
<i>If the Alleged Perpetrator is not a staff member, check all that apply and provide the name in the area provided below. "</i>		
<input type="checkbox"/> Another Resident <input type="checkbox"/> Family Member <input type="checkbox"/> Other		
Name:		
Witnesses:	Relationship to Resident:	



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### Interventions implemented:

*Provide a detailed description of steps taken by the facility to protect the residents in the facility with specific details on steps taken to protect any resident(s) involved in the incident and to prevent further incidents:*

To submit this form email it to [doh.ohcamco@doh.hawaii.gov](mailto:doh.ohcamco@doh.hawaii.gov)