HEALTH CARE PROTECTION PROGRAM
Risk Management
PO Box 3586, Victoria, B.C. V8W 3W6
Phone: (250) 356-1794 Fax: (250) 356-0661

HCPP Claim No.

LIABILITY CLAIM REPORTING FORM

Origin of Claim **Date Notified:**	Name of Agency _____ Address_____ Person to Contact Regarding this Claim_____ Telephone Number_____ Fax Number_____
Claim Description	Claimant/Patient Name_____ Provincial Health Number_____ Date of Incident/Occurrence_____ Potential Claim / Actual Claim **(Circle One)** Brief Description of Problem/Complaint/Incident alleged injury or property loss/damage: _____ _____ _____ _____ _____ _____ _____
Accompanying Documentation	Incident Report Enclosed Yes ☐ No ☐ Notice of Writ/Statement of Claim Enclosed Yes ☐ No ☐ Other, please note: _____ _____ _____

NOTE: DO NOT PROVIDE ANY INFORMATION REGARDING THIS EVENT TO ANY PERSON(S) OTHER THAN REPRESENTATIVES OF HCPP OR ADJUSTERS/LAWYERS ASSIGNED TO ACT FOR THE FACILITY.