



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 <input type="checkbox"/> No <input type="checkbox"/> Notice of Writ/Statement of Claim Enclosed Yes <input type="checkbox"/> No <input type="checkbox"/> 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.