

Location: _____

Form Completed By: _____ Phone #: _____ Date: _____

EXHALE INJURY/ INCIDENT REPORT

Please fax this completed form to:

Exhale Enterprises Incorporated, FAX: (212) 300-2326

ALL CLAIMS WILL BE CALLED IN BY CORPORATE OFFICE

INJURED PARTY (choose one)

CLAIM RECOMMENDATION

REPORT INFORMATION (choose one)

<p>Employee _____</p> <p>Guest/Member _____</p> <p>Other _____</p>	<p>____ Check here if claim should be filed by corporate office.</p>	<p>What type of report is this?</p> <p>____ New Report</p> <p>____ Follow up report</p> <p>Date of original report : _____</p>
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PERSONAL INFORMATION

<p>Name of injured person/guest:</p>	<p>Position:</p> <p>Social Security # (Associate only): ____ - ____ - ____</p>	<p>Age:</p> <p>DOB:</p>	
<p>Address:</p>	<p>City :</p>	<p>State :</p>	<p>Zip:</p>
<p>Daytime phone:</p>		<p>Evening phone: ()</p>	

INCIDENT DETAILS

<p>Date of incident</p>	<p>Time:</p>	<p>Location:</p>	
<p>How did staff become aware of incident?</p>			
<p>When did staff become aware of incident? Date:</p>		<p>Time:</p>	
<p>Staff person reporting:</p>		<p>Position:</p>	
<p>Was the injury due to equipment problem? Y N</p>		<p>If yes, what equipment?</p>	
<p>Body part injured (if applicable):</p> <p>Description of Item(s) stolen/lost:</p>			
<p>Extent and type of injury:</p> <p>Estimated Value of Property:</p>			
<p>Witness:</p>		<p>Phone:</p>	
<p>Address:</p>	<p>City:</p>	<p>State:</p>	<p>Zip:</p>

TREATMENT/ACTION ADMINISTERED

Type of first aid administered:		
Police Informed/Name of Officer:		Y: _____ N: _____
By whom:		Was emergency rescue called?
Sent to hospital?	Which one?	
Y N		
Was family notified?	Who?	When?
Y N		

Follow-up actions:

Follow-up actions by: _____ Date: _____

** If you are having trouble sending this form, please save and send to bcforms@exhalespa.com*