EXAMINEE/CERTIFICANT INCIDENT REPORT

Person Filing the Incident Report:

Your Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Examinee/Certificant Involved in Incident:

Name of Individual: _____

Name of Business: _____

Address: _____

City: _____ State: _____ Zip: _____

Business Phone: _____ Email Address: _____

Details of the Incident:

1) Please describe the incident in detail. Include all facts, dates, names of individuals involved, copies of receipts, bills or other correspondence. Please use additional sheets as necessary.

2) Have you contacted the business or individual about this incident? ☐ No ☐ Yes, date: _____

If yes, what was their response: _____

3) Have you filed a report regarding this matter with another agency? ☐ No ☐ Yes, date: _____

If yes, what was their response: _____

4) Has a regulatory board been notified of this incident? ☐ No ☐ Yes, date: _____

5) Has a regulatory board taken action on this individual related to this incident? ☐ No ☐ Yes, date: _____

If yes, what was their response: _____

NATIONAL HEALTHCAREER ASSOCIATION

ExCPT®

Attestation:

These statements are true and accurate to the best of my knowledge. I understand that these statements may be used in all phases of NHA's investigations and administrative procedures.

Print Name _____ Today's Date _____

Your Signature _____

We will not disclose your identity to relevant parties unless you sign the following statement:

By signing below, I authorize NHA to disclose my identity as the person who filed this incident report. My identity may be disclosed to the subject(s) of this report and other persons during the course of the investigations.

Print Name _____ Today's Date _____

Your Signature _____

This form should be mailed to:

National Healthcareer Association
Attn: Compliance
11161 Overbrook Road
Leawood, Kansas 66211
(800) 499-9092
Fax (913) 661-6291