

INCIDENT REPORTING FORM
Individual Professional Liability (Malpractice) Insurance



Pharmacist's / Technician's Details

Name of insured involved in Incident _____ Please check one
Pharmacist Pharmacy Technician

Business Number _____ Residence Number _____ Mobile Number _____

Certificate Number (or OPA Member number) of Individual Professional Liability (Malpractice) Insurance _____

Details of Incident

Note: If notice received from Ontario College of Pharmacists (OCP), attach copy of notice and any subsequent correspondence, also complete relevant questions below:

Date of Error or Incident _____

Date of First Knowledge of Incident or First Notice from OCP _____

Name of Patient _____

Details of Error, Incident or Basis of Complaint to OCP _____

Has treating physician been notified of Error or Incident?
 Yes No

Has the pharmacy (store) insurer been notified?
 Yes No

Outline steps taken to rectify Error, Incident or Complaint to OCP _____

Are you aware of any verbal or written complaint (other than complaint to OCP) or demand made by patient?
 Yes No

If 'yes', please attach copy of complaint or demand. If verbal, provide details _____

Have any ill effects been reported by patient?
 Yes No

If 'yes' please describe _____

Please fax or email a copy of this form with attachments to:
Adelaide Marquardt,
HUB International Limited
Fax: 416-597-2313 or Email: adelaide.marquardt@hubinternational.com