Exhibit C2

HAWAII DEPARTMENT OF HUMAN SERVICES – Division of Vocational Rehabilitation

**INCIDENT REPORT**

Report Date:

Vendor Company Name:

Incident Reported by Vendor Representative:

VR Client/Participant Name Involved in Incident:

VR Counselor Name:

DVR Purchase Order #:

Date of Incident:

Time of Incident:

Location of Incident, if applicable:

Did the Vendor Representative witness the incident? [ ]  Yes [ ]  No

Incident Summary:

Incident Report Prepared By:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_