

## Workplace Violence Incident Report Form

Person Completing Form			
<b>Full Name:</b>	<b>Date:</b>	<b>Department:</b>	
<b>Title:</b>	<b>Cell Phone:</b>	<b>Email:</b>	
Incident Information			
<b>Date of Incident:</b>	<b>Time of Incident:</b>	<b>Classification (1, 2, 3, 4):</b>	
<b>Location/Department of Incident:</b>	<b>Address:</b>	<b>Supervisor:</b>	
Incident Directed At			
<b>Full Name</b>	<b>Department Worked</b>	<b>Supervisor</b>	
<b>Cell Phone</b>	<b>Email</b>	<b>Friend/Family Contacted:</b>	
Type of Incident (Mark all that are applicable)			
<input type="checkbox"/> Physical Assault	<input type="checkbox"/> Property Damage	<input type="checkbox"/> Threats	
<input type="checkbox"/> Verbal abuse	<input type="checkbox"/> Act of violence with injury	<input type="checkbox"/> Written threat	
<input type="checkbox"/> Intimidation or harassment	<input type="checkbox"/> Conditional threat (if-then)	<input type="checkbox"/> Direct threat (i will...)	
<input type="checkbox"/> Act of violence property damage	<input type="checkbox"/> Vandalism (employer's property)	<input type="checkbox"/> Animal attack	
<input type="checkbox"/> Grabbed	<input type="checkbox"/> Pushed	<input type="checkbox"/> Slapped	
<input type="checkbox"/> Kicked	<input type="checkbox"/> Scratched	<input type="checkbox"/> Hit with fist	
<input type="checkbox"/> Hit with object	<input type="checkbox"/> Knifed (or attempted)	<input type="checkbox"/> Shot (or attempted)	
<input type="checkbox"/> Sexually assaulted	<input type="checkbox"/> Assaulted with weapon	<input type="checkbox"/> Threatened with weapon	
<input type="checkbox"/> Bitten	<input type="checkbox"/> Verbally threatened	<input type="checkbox"/> Bomb threat	
<input type="checkbox"/> Verbally harassed	<input type="checkbox"/> Vandalism (own property)	<input type="checkbox"/> Robbery	
<input type="checkbox"/> Arson	<input type="checkbox"/> Other		
<b>Was a weapon involved?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Did law enforcement respond?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Was manager/supervisor present?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Any witnesses?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Associated Individuals (check all that apply)			
<input type="checkbox"/> Witness	<input type="checkbox"/> Injured	<input type="checkbox"/> Other	Name
<input type="checkbox"/> Witness	<input type="checkbox"/> Injured	<input type="checkbox"/> Other	Name
<input type="checkbox"/> Witness	<input type="checkbox"/> Injured	<input type="checkbox"/> Other	Name
<input type="checkbox"/> Witness	<input type="checkbox"/> Injured	<input type="checkbox"/> Other	Name

**Workplace Violence Incident Report Form (cont'd.)**

<b>Law Enforcement Agencies if Applicable</b>			
Agency	Contact Information	Case #	Other Information
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<b>Who Threatened or Assaulted</b>			
<input type="checkbox"/> Client/customer	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Passenger	<input type="checkbox"/> Spouse/Partner
<input type="checkbox"/> Student	<input type="checkbox"/> Robber/Burglar	<input type="checkbox"/> Family/friend of client or employee	
<input type="checkbox"/> Supervisor/manager	<input type="checkbox"/> Animal	<input type="checkbox"/> Former Spouse/Partner	
<input type="checkbox"/> Parent	<input type="checkbox"/> Stranger	<input type="checkbox"/> Other -	
<b>Post Incident Actions</b>			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medical attention as a result of the incident?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Work missed as a result of the incident?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Workers' compensation claim filed?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was the incident reported to the immediate supervisor or manager?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was a police report filed?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was immediate counseling offered to affected workers and witnesses?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was critical incident debriefing provided to all affected employees?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was post-trauma (follow-up) counseling provided to all affected employees?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was the victim advised about legal rights?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was all counseling provided by a professional counselor?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was the counseling effective given employee feedback?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:	
<b>Supervisory Actions to Date:</b>			
<b>Full Name</b>	<b>Start Review Date</b>	<b>End Review Date</b>	

**Submit to Diane Young for follow up and filing.**

**Diane Young Use Only**

**Notes/Comments:**

**File Status**

<input type="checkbox"/> <b>Closed</b>	<b>Date Closed:</b>	<b>Remedy/Action Taken:</b>
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<b>Name:</b>	<b>Initial:</b>	<b>Date Final Review:</b>
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