WORKPLACE VIOLENCE INCIDENT REPORT FORM

Complete this form in conjunction with the Workplace Violence Prevention Plan.

PERSON REPORTING:

Name:	Title:	Department:
Phone:	Email:	Today's Date:

INCIDENT INFORMATION

Date of Incident:	Time of Incident:		
Location of Incident:	Address and town, if off campus:		
Type of Incident:	☐ Threats ☐ Property Damage	☐ Physical Assault ☐ Verbal abuse	☐ Animal Attacks Other (specify)
Was a weapon involved?	☐ No ☐ Yes (type of weapon)		
Did Law Enforcement respond?	☐ No ☐ Yes (specify Police Department)		
Was Manager/Supervisor/HR present?	☐ No ☐ Yes (name and title)		

INDIVIDUALS INVOLVED (use additional sheets as needed)

Name: Phone:	Title: Email:	☐ Assailant ☐ Victim ☐ Witness
Name: Phone:	Title: Email:	☐ Assailant ☐ Victim ☐ Witness
Name: Phone:	Title: Email:	☐ Assailant ☐ Victim ☐ Witness

ASSAILANT(S) RELATIONSHIP TO VICTIM(S)

☐ Co-worker/current employee	☐ Patient	☐ Contractor/vendor
☐ Former co-worker/employee	☐ Patient's family	☐ Student
☐ Supervisor/Manager	☐ Visitor	☐ Other:

ASSAILANT(S) BACKGROUND (If known, check all that may apply)

☐ Consequence of assailant(s)'s condition	☐ Dissatisfied with care/ service	☐ Prior history of violence
☐ Occurred while processing information	☐ Employment related	☐ Suspected substance abuse
☐ Occurred while providing direct care	☐ Interpersonal conflict	☐ Grief
☐ Other:		

INJURY INFORMATION

☐ Physical injury? ☐ No ☐ Yes If yes, describe:
☐ Medical care required? ☐ No ☐ Yes If yes, location of treatment:

DISPOSITION AND FOLLOW UP ACTIONS (Check all that apply)

☐ Situation defused without Police ☐ Police Investigation ☐ Employee Assistance Program contacted ☐ Human Resources notified	☐ Occupational Medicine referral ☐ Supervisor/Manager notified ☐ Patient Assignment Adjusted (per request) ☐ Other, specify:
Disposition of Assailant: ☐ Stayed on premises ☐ Escorted off premises ☐ Left on own ☐ Other, specify:	Restraints used ☐ No ☐ Yes If yes, used by: ☐ Clinical staff ☐ Police Type of restraint: Additional description:

DETAILED DESCRIPTION OF EVENT: (additional relevant information)

Name of person completing report: Date

WHAT WERE YOU DOING AT THE TIME OF THE INCIDENT: (Usual job duties, working independently or with others)