

WORKPLACE VIOLENCE INCIDENT REPORT

To be completed by the individual investigating the incident. Return completed form within 2 days following incident to Human Resources. **Attach witness statements to this form.**

Report submitted by:	Date:
General Description:	Telephone:

Date of Incident:	Time:
Address/Location of Incident:	

Individuals involved in the incident (use additional sheet(s) if necessary)

Name:	Name:
<input type="checkbox"/> Victim or <input type="checkbox"/> Assailant	<input type="checkbox"/> Victim or <input type="checkbox"/> Assailant
Title:	Title:
Division:	Division:
Phone:	Phone:
Immediate Supervisor:	Immediate Supervisor:

Assailant Relationship to Employee

<input type="checkbox"/> Co-worker	<input type="checkbox"/> Former Employee
<input type="checkbox"/> Other (specify)	

Possible Reason for Incident: (If known, check all that apply)

<input type="checkbox"/> Conflict with co-worker(s)/former co-worker	<input type="checkbox"/> Receiving corrective action
<input type="checkbox"/> Conflict with management	<input type="checkbox"/> Other (specify)

Nature of Incident

<input type="checkbox"/> Stalking
<input type="checkbox"/> Engaging in actions intended to frighten, coerce, or induce duress
<input type="checkbox"/> Destruction of Property
<input type="checkbox"/> Physical Assault - Hitting, fighting, pushing, or shoving
<input type="checkbox"/> Armed Assault - Use of object as weapon (specify)
<input type="checkbox"/> Armed Assault - Use of weapon such as gun, knife, etc. (specify)
<input type="checkbox"/> Verbal Harassment
<input type="checkbox"/> Sexual Harassment
<input type="checkbox"/> Other (specify)

How was the incident communicated? (Check one or more)

<input type="checkbox"/> Communicated directly to victim	<input type="checkbox"/> Verbal	<input type="checkbox"/> Mail	<input type="checkbox"/> Note	<input type="checkbox"/> Email
<input type="checkbox"/> Communicated to another person	<input type="checkbox"/> Verbal	<input type="checkbox"/> Mail	<input type="checkbox"/> Note	<input type="checkbox"/> Email
<input type="checkbox"/> Other (specify)				

Victim Injury (Check all that apply)

<input type="checkbox"/> Physical injury
<input type="checkbox"/> Physical Injury - Medical care required
<input type="checkbox"/> Other

Initial Response or Follow up Activity: (Check all that apply)

<input type="checkbox"/> Situation defused	<input type="checkbox"/> Occupational Medicine notified
<input type="checkbox"/> Security called	<input type="checkbox"/> Law Enforcement notified If Yes, Name of Agency and Report Number:
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Employee Assistance Program referral
<input type="checkbox"/> Video Surveillance of the incident?	<input type="checkbox"/> Video Footage Retained for Investigation Purposes

Describe Incident in Detail

Include what happened, where, who was involved, what you heard, saw, etc.

List Names of Other Witnesses

Signature

Date

Person Receiving Witness Statement

Date

If there were witnesses to the incident, witness statements should be obtained and written in their own words. Witness statements should accompany this form.

Upon completion of investigation, attach a findings/follow-up document to this form.