Workplace Violence Incident Report

Note: In completing this form, attach all supporting documents; such as continuation sheets and police reports

Affected Party(s): _____
Supervisor: _____
Department/Phone Ext. _____

Incident Information:

Date of Incident: _____

Time of Incident: _____

Location of Incident (be specific): _____

Description of Incident: (Narrative)
_____
_____
_____

Has this or a similar incident ever happened to you before? If so, please explain.
_____
_____
_____

If you incurred any injury whatsoever, (physical-emotional) please describe the injury, in detail, and the location of any treatment received.
_____
_____
_____

List all witnesses of the incident:

Name: _____

Department: _____

Contact Number: _____

Was a weapon involved? If so, specify type and to what extent:

_____

Aggressor Information:

Name:_____
Department: *(if an employee)* _____
Supervisor: *(if an employee)* _____
Relationship to aggressor*: (if stranger, indicate relationship, if any)*_____
Had anything occurred in the past to make you feel this would happen? If so, please explain. _____
_____
_____

Home address/vehicle information: *(if not an employee)*
_____
_____

Follow-up Information:

Did this incident cause lost workdays? If so, how many? _____

What action did department head take? If so, when (dates) and by whom?_____
_____

Have you had any counseling or any form of emotional support since the incident? If not, would you like to be afforded this? _____
_____

As you see it, does something need to be done to avoid such an incident from happening again? If so, explain.
_____
_____
_____

_____	_____
Report Completed by	Department Head Signature
_____	_____
Title	Title
_____	_____
Date	Date

Distribution (via hard copy, fax OR email):

Original to Department Head
Copy to County Administrator
Copy to Self-Insurance