**WORKPLACE VIOLENCE INCIDENT REPORT FORM**

Use this form to report a workplace violence incident. If possible, a report should be completed within 24 hours of the event.

Date of Report: [DATE]

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| **PERSON FILING REPORT** |

Full Name: [FULL NAME] Title/Role: [TITLE/ROLE]

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: [DATE]

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| **THE INCIDENT** |

Date of Incident: [DATE OF INCIDENT] Time: [TIME]  AM  PM

Location: [LOCATION]

Describe the Incident in detail (including events leading up to the incident and how it ended): [DESCRIBE THE INCIDENT]

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| **PERSON(S) INVOLVED** |

1. Full Name: [FULL NAME] Job Title: [JOB TITLE]
2. Full Name: [FULL NAME] Job Title/Other Identifier: [JOB TITLE]
3. Full Name: [FULL NAME] Job Title/Other Identifier: [JOB TITLE]

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| **INJURIES** |

Was anyone injured?  Yes  No

If yes, describe the nature and extent of injuries: [INJURY DESCRIPTION]

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| **WITNESSES** |

Were there witnesses to the incident?  Yes  No

If yes, enter the witnesses’ names and contact info:

1. Full Name: [NAME]

Job Title/Other Identifier: [JOB TITLE]

1. Full Name: [NAME]

Job Title/Other Identifier: [JOB TITLE]

1. Full Name: [NAME]

Job Title/Other Identifier: [JOB TITLE]

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| **POLICE / MEDICAL SERVICES** |

Police Notified?  Yes  No If yes, was a report filed?  Yes  No

Was medical treatment provided?  Yes  No  Refused

If yes, where was medical treatment provided?  On site  Hospital  Other: [OTHER]

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| **OFFICE USE ONLY** |

Report provided to : [FULL NAME] Date: [DATE]