EMPLOYEE WORKPLACE VIOLENCE INCIDENT REPORT

Name of Employee: _____

Date of Incident: _____/____/_____ Time of Incident: _____ A.M. or P.M.

Location of Incident (i.e. Building, Intersection): _____

Where did the Incident Occur: _____

_____

Did the incident occur on premises? Yes or No Date Reported to Supervisor: ____/____/____

Name of individuals involved in incident:

Witness: Yes or No, If Yes please provide name(s):

How did the incident occur and what were you doing at the time of the incident?

How did the incident end (if applicable)?

Did you sustain any personal injury? Was medical treatment provided at the time of Incident? Be specific:

If yes, provide medical provider information: _____

_____

Employee Signature: _____ Date: ____/___/_____

Supervisor or Nurse: _____ Date: ____/____/_____

Please return this form to Central Office/Human Resources/Personnel Department