

# Workplace Violence Incident Reporting Form



Date of incident \_\_\_\_\_

Time of incident: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Title: \_\_\_\_\_

Names of other affected employees: \_\_\_\_\_

Department: \_\_\_\_\_

Work Location: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Location of incident: \_\_\_\_\_

Were there injuries \_\_\_\_\_

Extent of injuries, if any: \_\_\_\_\_

Was medical treatment required \_\_\_\_\_

Explain: \_\_\_\_\_

Was the employee hospitalized \_\_\_\_\_

Explain \_\_\_\_\_

Description of incident:

Physical Abuse:

Verbal Abuse:

Threat:

Other:

Was the assailant a:

Co-Worker:

Faculty:

Student:

Supervisor:

Administrator:

Other:

Were the Police notified:

Yes

No

Was anyone arrested:

Yes

No

Narrative of

incident(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

