DEPARTMENT OF PUBLIC SAFETY
WORKPLACE VIOLENCE INCIDENT REPORT

To be completed by the individual investigating the incident. Return completed for within 7 days following incident to the DPS Human Resource Office, Workplace Violence Coordinator. Attach victim/witness statements to this form.

Report submitted by:	Date:
Title:	Telephone:

Date of incident:	Time: ☐ AM ☐ PM
Address/Location of Incident:	

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

Name:	Name:
☐ Victim or ☐ Assailant	☐ Victim or ☐ Assailant
Title:	Title:
Division:	Division:
Phone:	Phone:
Immediate Supervisor:	Immediate Supervisor:

Assailant Relationship to Employee

☐ Co-worker	☐ Customer/Client
☐ Supervisor	☐ Person In Custody
☐ Former Employee	☐ Stranger
☐ Spouse/Family Member	☐ Other

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

☐ Conflict with co-worker(s)/former co-worker	☐ Alcohol/Drugs in the workplace
☐ Conflict with supervisor	☐ Mental health problems
☐ Family/domestic dispute	☐ Reduction in force
☐ Receiving a poor performance appraisal	☐ Demotion
☐ Receiving disciplinary action	☐ Dismissal
☐ Racial Tension	☐ Resisting arrest
☐ Other (specify)	

Type of Incident (Check one or more)

Threat

☐ Communicated directly to victim	☐ Verbal	☐ Mail	☐ Note	☐ Email
☐ Communicated to another person	☐ Verbal	☐ Mail	☐ Note	☐ Email
☐ Other (specify)				

Intimidation

☐ Stalking
☐ Engaging in actions intended to frighten, coerce, or induce duress
☐ Other (specify)

Physical Attack

☐ Hitting, fighting, pushing, or shoving
☐ Use of object as weapon (specify)
☐ Use of weapon such as gun, knife, etc. (specify)
☐ Other (specify)

Check if victim sustained physical or traumatic/emotional injury in any of the following categories:

☐ Physical injury	☐ Trauma/Emotional injury
☐ Medical care required	☐ Death

Initial Response: (Check all that apply)

☐ Situation defused	☐ Medical Director notified
☐ Security called	☐ Member Assistance Team notified
☐ Workplace Violence Coordinator notified	☐ Employee Assistance Program referral
☐ Law Enforcement notified If Yes, Name of Agency and Report Number:	
☐ Other (specify)	

Follow-up Response: (Check all that apply)

☐ Medical treatment provided to victim	☐ Victim referred to counseling
☐ Medical treatment provided to assailant	☐ Assailant referred to counseling
☐ Workers' Compensation claim filed	