

Appendix D-12: Workplace Violence/Client Aggression Event Report Form and Investigation Tool (OSACH 2006)

PART 1 - EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)		
Name		Position
Dept./Unit		Shift
Date and time of incident		
Date and time incident reported		
Incident reported to		
Location of incident		
<input type="checkbox"/> client care area	<input type="checkbox"/> public area on-site	<input type="checkbox"/> restricted area on-site
<input type="checkbox"/> parking lot or walkway	<input type="checkbox"/> community	<input type="checkbox"/> client's home
Work location if off-site		
Were the emergency response measures initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please indicate the classification of the incident (please refer to explanation provided)		
<input type="checkbox"/> Type I (Criminal Intent)	Person has no relationship to the workplace	
<input type="checkbox"/> Type II (Client or Customer)	Person is a client, visitor or family member of a client at the workplace who becomes violent toward a worker or another client; or worker becomes violent toward a client, visitor or family member of a client	
<input type="checkbox"/> Type III (Worker-to-worker)	Perpetrator is an employee or past employee of the workplace	
<input type="checkbox"/> Type IV (Personal Relationship)	Perpetrator usually has a relationship with an employee (e.g. domestic violence in the workplace)	
Describe the event including persons involved		
Does the person involved have a history of previous incidents? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Incident Type		
<input type="checkbox"/> Threat	<input type="checkbox"/> Physical assault	<input type="checkbox"/> Verbal abuse
<input type="checkbox"/> Discrimination or harassment	<input type="checkbox"/> Robbery, arson, vandalism	<input type="checkbox"/> Carrying a weapon

Injury Type		
<input type="checkbox"/> Strain or sprain	<input type="checkbox"/> Cut or laceration	<input type="checkbox"/> Contusion
<input type="checkbox"/> Bitten	<input type="checkbox"/> Pinched	<input type="checkbox"/> Psychological
Other (specify)		
Was medical attention or first aid required? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, provide details		
Description of incident (Please describe what happened in the space below)		
Who was involved?		
What events lead up to the incident?		
Were other individuals involved? (e.g. staff, visitors, clients, etc.)		
What precipitated the incident?		
Other		
Actions taken		
Please indicate concerns, issues and actions taken (e.g. initiated emergency response plan, contacted supervisor, police or security, emergency service personnel, etc.)		
Witness(es)		
Name	Contact information	
1.		
2.		
3.		
4.		
Other Information		