

WORKPLACE VIOLENCE INCIDENT REPORT LOG

Employee Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Job Title:		Department:
Supervisor Name:		Supervisor Title:
Date of Incident:	Time of Incident: am/pm	Specific Location (e.g., room number, floor, ward, etc.):

Detailed description of the incident in the employee's own words:

Who carried out the violence or assault? (to be completed by the employee)

<input type="checkbox"/> Patient/client/customer <input type="checkbox"/> Family/friend of patient/client/customer <input type="checkbox"/> Stranger with criminal intent <input type="checkbox"/> Co-worker	<input type="checkbox"/> Supervisor/manager <input type="checkbox"/> Spouse or partner (current or former) <input type="checkbox"/> Parent or relative <input type="checkbox"/> Other _____
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At the time of the incident were you? (to be completed by the employee)

<input type="checkbox"/> Completing usual job duties <input type="checkbox"/> Working in poorly lit areas <input type="checkbox"/> Rushed <input type="checkbox"/> Working during a low staffing level <input type="checkbox"/> In a high-crime area	<input type="checkbox"/> Isolated or alone <input type="checkbox"/> Unable to get help or assistance <input type="checkbox"/> Working in a community setting <input type="checkbox"/> Working in an unfamiliar or new location <input type="checkbox"/> Other _____
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Where did the incident occur?

<input type="checkbox"/> Patient/client room <input type="checkbox"/> Emergency room/urgent care <input type="checkbox"/> Hallway <input type="checkbox"/> Waiting room <input type="checkbox"/> Restroom/bathroom	<input type="checkbox"/> Parking lot/outside premises <input type="checkbox"/> Personal residence (home health care) <input type="checkbox"/> Break room/cafeteria <input type="checkbox"/> Other _____
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Type of incident (check all that apply)

Physical assault <input type="checkbox"/> Biting <input type="checkbox"/> Choking <input type="checkbox"/> Grabbing <input type="checkbox"/> Hair pulling <input type="checkbox"/> Kicking <input type="checkbox"/> Punching/slapping <input type="checkbox"/> Pushing/pulling <input type="checkbox"/> Scratching <input type="checkbox"/> Spitting at/on <input type="checkbox"/> Other _____	Assault with weapon or object <input type="checkbox"/> Gun <input type="checkbox"/> Knife <input type="checkbox"/> Other _____ Sexual assault or intimidation <input type="checkbox"/> Rape/attempted rape <input type="checkbox"/> Unwanted verbal/physical sexual contact <input type="checkbox"/> Physical display <input type="checkbox"/> Other _____	Verbal intimidation <input type="checkbox"/> Bullying <input type="checkbox"/> Harassment <input type="checkbox"/> Threatening <input type="checkbox"/> Other _____ Physical intimidation <input type="checkbox"/> Following/stalking <input type="checkbox"/> Physical threats <input type="checkbox"/> Other _____ <input type="checkbox"/> Post-incident stress <input type="checkbox"/> Animal Attack <input type="checkbox"/> Other _____
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Did the employee get medical treatment for the injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was security or law enforcement contacted?	<input type="checkbox"/> Yes Who? _____	<input type="checkbox"/> No
Did the employee take time off work?	<input type="checkbox"/> Yes How long? _____	<input type="checkbox"/> No

Is there a continuing threat to employees?
 No Yes **Actions taken to protect employees:** _____

Report Completed By (Name):	Title:
Phone number:	Email:
Date Completed:	Date Submitted: