WORKPLACE VIOLENCE INCIDENT REPORT FORM

Facility Information:

Name: _____

Address: _____

City: _____

State, ZIP: _____

Physician/Employer: _____

Phone: _____ Fax: _____

Person reporting incident: _____

Person investigating incident: _____

Date of incident: _____ Time of incident: _____

Date of report: _____

Name of Employee(s) Affected by Incident:

Name: _____

last first middle

D.O.B.: _____ SS# : _____ (optional)

☐ Multiple employees were effected - list attached

☐ Patients were effected - attach list

☐ Incident was reported to police If "yes" attach police report.

Description of occurrence/incident:

_____

_____

_____

Incident Classification:

☐ Minor - the incident did not result in harm to employee but had the potential to

☐ Major - the incident did result in direct or potential harm to employee

☐ Major - multiple employees were effected by incident

☐ Major - multiple employees and patients were effected by inciden