



# Workplace Violence Incident Report Form

This form should be completed immediately following a workplace violence incident. Affected employees should be given assistance to complete all fields, if required. Once completed, make a copy of the form for all affected employees and return the original to the employee's supervisor.

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

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

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

Department / Unit: \_\_\_\_\_

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

Location of Incident: \_\_\_\_\_ Were there any injuries?  Yes  No

Extent of injuries: \_\_\_\_\_

Was medical treatment required?  Yes  No

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

Was the employee hospitalized?  Yes  No

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

Description of incident:  Physical abuse  Verbal abuse  
 Threat  Other: \_\_\_\_\_

Was the assailant a:  Client or Patient  Co-worker or Supervisor  
 Intimate partner or Loved one  Other: \_\_\_\_\_

Were the Police notified?  Yes  No

Was the assailant arrested?  Yes  No

Please describe the incident in detail including the preceding events:

List / describe actions taken to prevent future incidents: