



## WORKPLACE VIOLENCE REPORT FORM

Date and Time:	Reporting Method (e.g. in-person, over phone, email):
Employee Completing the Form:	Department/Division:
Name of the Individual Reporting the Incident:	Contact Information of Reporting Party:
Date of Incident:	Time of Incident:
Street Address of Location Where Incident Occurred:	City/State/Zip:
Location Type (ex: office, clinic, park, hospital, campus):	Area Where Incident Occurred (ex: main lobby, room#)
Safety Incident Type:  <input type="checkbox"/> Threat of Act of Workplace Violence <input type="checkbox"/> Unsafe Condition <input type="checkbox"/> Unsafe Act <input type="checkbox"/> Public Access Issue <input type="checkbox"/> Suggestion <input type="checkbox"/> Near Miss <input type="checkbox"/> Other:	Safety Incident Cause: (Defective equipment, poor ventilation or lighting, exposure to unsafe condition, physical attack, procedures not followed, etc.)
Names of witnesses or others involved:	
Classification of circumstances at the time of the incident: <input type="checkbox"/> Performing usual job duties <input type="checkbox"/> Isolated or working alone <input type="checkbox"/> Working in high crime area <input type="checkbox"/> Lack of equipment <input type="checkbox"/> Working in a poorly lit area <input type="checkbox"/> Other Circumstances	
Type of medical treatment provided:  <input type="checkbox"/> None <input type="checkbox"/> First-Aid <input type="checkbox"/> Fire Paramedic or Ambulance <input type="checkbox"/> Hospital <input type="checkbox"/> Triage with department nurse	

Was environmental sampling done: <input type="checkbox"/> YES <input type="checkbox"/> NO	Which agency conducted the sampling:
Was security or police involved: <input type="checkbox"/> YES <input type="checkbox"/> NO	Security or police agency:
Name or Person(s) who conducted the investigation:	Job Title:
Were findings from the investigation substantiated:	Date of investigation or review:
<p>Detailed incident description, including:</p> <ul style="list-style-type: none"> <li>- All employees and individuals involved before, during and after the incident.</li> <li>- Detailed account of the incident as events occurred, including a specific timeline.</li> <li>- Findings and outcomes from the investigation.</li> </ul>	
<p>What actions have been taken, or are recommended to prevent incident reoccurrence (check all that apply):</p> <input type="checkbox"/> Equipment "Out of Service" for repairs <input type="checkbox"/> Other: (Specify) <input type="checkbox"/> Order new or additional equipment <input type="checkbox"/> Facilities Maintenance Service Requested <input type="checkbox"/> New or additional warning signage <input type="checkbox"/> Ergonomic evaluation or job assessment <input type="checkbox"/> Safety procedures to be reviewed or developed	

*(After form is complete, please give to your supervisor and email to DEI@kerncounty.com)*