DEPARTMENT OF STATE
Workplace Violence
Initial Incident Report

INSTRUCTIONS: Part 1 is to be completed by the Division Director/Manager/Supervisor and faxed to the Division of Administration at 609-633-8610 within 24 hours of an incident of Violence in the Workplace. A copy of the form must be maintained at the worksite. Part 2 must be completed within 48 days of the incident and submitted to the Division of Administration.
NOTE: You may amend Part 1 if appropriate when completing Part 2.

Part 1

Individuals/ Property involved in incident:
(Please note that separate reports will need to be completed for each additional victim)

A. Victim's Name _____ Job Title _____
Division _____ Phone # _____

B. Property Damage: Yes _____ No _____ Please describe _____

_____

Incident Information:

Date: _____ Time: _____ Location (if different from above): _____

Incident Type (circle one): Threats and/or threatening behavior Harassment and/or intimidation Physical Assault

Other (please specify): _____

Describe incident: _____

_____

Weapons Involved: Yes _____ No _____ If yes, please describe: _____

_____

Any of the victims injured: Yes _____ No _____ Name(s): _____

_____

Specific injury: _____

Police response sought: Yes _____ No _____ Name of Police Dept. _____

Perpetrator Information:

Circle one: Intruder Client Former Employee Current Employee Supervisor/Manager Family/Friend of employee Other _____

Perpetrator's Name (if known): _____

Address: _____

Immediate Action Taken:

Who was notified: _____

Employee received medical attention: Yes_____ No _____ If yes, describe _____

_____

Employee or Co-Worker offered Counseling? Yes _____ No ____ EAS or Other _____

Form Completion

Printed Name & Phone Number of Worksite Manager (or designated person in charge): _____ Phone #: _____

Signature of Worksite Manager: _____ Date: _____

Part 2

Further Action/Notification

Was any further action taken by the worksite manager: Yes _____ No _____ If yes, specify: _____

_____

Has victim or coworker(s) had any counseling or supportive help since the incident: Yes ____ No ____ If yes, who provided counseling: _____

Was the bargaining unit representative notified: Yes ____ No ____ Who: _____

_____

Incident disposition (circle all that apply): No action taken Arrest Disciplinary Action Request Other:

_____

Additional Information:

Did victim lose any work days: Yes _____ No _____ Specify _____

_____

Did victim indicate that an incident might occur: Yes ___ No ___ If yes, describe: _____

_____

Has this type of similar incident(s) happened previously to the victim while at this location: Yes ___ No ___ Specify: _____

What does the victim feel can be done in the future to avoid such an incident: _____

_____

Was the perpetrator involved in previous incidents: Yes _____ No _____ If yes, specify: _____

_____

What steps have been taken to prevent similar incidents, specify: _____

_____

Has any other corrective action been taken, specify: _____

_____

Comments: _____

_____

_____

Form Completion

_____ _____

Printed Name of Worksite Manager/Supervisor/Designated Person in Charge Phone #

_____ _____

Signature of Worksite Manager/Supervisor/Designated Person in Charge Date