



Workplace Violence Incident Report Form

Tompkins County Department of Human Resources
 125 East Court St, Ithaca, NY 14850
 607-274-5526

EMPLOYEE (VICTIM) INFORMATION:

Today's Date		Employee (victim) ID #	
Employee (victim) First Name		Employee (victim) Last Name	
Street Address		City, State, Zip	
Phone Number			
Job Title		Department	
Supervisor		Supervisor email	

INCIDENT INFORMATION:

Date of Incident		Time of Incident	
Shift	<input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> No Shift i.e., 8 to 5	Location of Incident	
Were you injured?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, nature/extent of injury?	
Did you seek medical treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please fill out a Workplace Employee Injury/Incident Report in addition to this form. https://fweb.tompkins-co.org/Forms/TCWII	
Nature of Harassment	<input type="checkbox"/> Harassed by email or other written <input type="checkbox"/> Verbal Harassment <input type="checkbox"/> Intimidation <input type="checkbox"/> Physical Assault <input type="checkbox"/> Armed Assault <input type="checkbox"/> Destruction of Property <input type="checkbox"/> Stalking <input type="checkbox"/> Other, please explain below		
Other – please explain			

OTHER EMPLOYEES:

Were there any other employees involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list below	
Name of Employee(s):		Title of Employee(s):	

WITNESS INFORMATION:

Witness Name(s):		Witness Phone Number(s)	

Describe Incident:

- Include events leading up to the incident
- Specific language of the threat
- Specific details of the threat or act of violence
- How the incident ended

Provide details of incident:

(Attach additional sheets if necessary)

ASSAILANT/PERPETRATOR INFORMATION:

Assailant(s)/Perpetrator(s) Relationship to Victim	<input type="checkbox"/> Coworker <input type="checkbox"/> Supervisor <input type="checkbox"/> Client/Customer <input type="checkbox"/> Patient <input type="checkbox"/> Visitor/Public <input type="checkbox"/> Person in Custody <input type="checkbox"/> Former Employee <input type="checkbox"/> Contractor/Vendor <input type="checkbox"/> Spouse/Partner/Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other:		
Name of Assailant(s)/Perpetrator(s) (if known):		Name of Assailant(s)/Perpetrator(s) (if known):	

Suggestions for preventing a similar incident in the future:	
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Employee Signature

Date

SUPERVISOR INFORMATION:

Date the employee notified you of the incident?		Time of notification:	
Did you offer the victim EAP services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If not, why?	
Were the police called?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did they respond?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was a report filed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	DR#	
Was Assailant arrested?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arrest Date and Time?	
Charges?		Action taken by Supervisor?	
Suggestions for preventing a similar incident in the future?			
Are you also the Department Head?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the Department Head notified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What date was the Department Head notified?		If the Department Head wasn't notified, why?	

Supervisor Signature

Date

DEPARTMENT HEAD:

Department Head comments:	
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Department Head Signature

Date

HUMAN RESOURCES:

Commissioner comments:	
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Commissioner Signature

Date

COUNTY ADMINISTRATION:

County Administration comments:	
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County Administration Signature

Date