

Violent Act Incident/Injury Report Form

Date of Incident	Time	Day of Week															
Location of Incident (Facility name, address, specific location within or on the grounds of the facility - if applicable map or sketch on reverse side):																	
Victim Description: <input type="checkbox"/> Employee <input type="checkbox"/> Patient/Client <input type="checkbox"/> Visitor		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female															
If the Victim is an Employee: Name of Employee: _____ Job Title: _____ Assigned Work Location: _____ Social Security Number: _____		Member of Labor Organization: Yes ___ No ___															
Supervisor: _____		Has supervisor been notified? Yes <input type="checkbox"/> No <input type="checkbox"/>															
Description of the type of Violent act as: <u>Defensive</u> Threat of assault with no physical contact: _____ <u>Acting Out</u> Physical assault with contact but no physical injury: _____ Physical assault with mild soreness, surface abrasions, scratches, or small bruises: _____ Physical assault major soreness, cuts, or large bruises: _____ Physical assault with severe lacerations, a bone fracture, or a head injury: _____ Physical assault with loss of limb or death: _____																	
Body Part(s) Injured: <input type="checkbox"/> NA <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">___ Head/face</td> <td style="width: 33%;">___ Shoulder L R</td> <td style="width: 33%;">___ Leg L R</td> </tr> <tr> <td>___ Eye L R</td> <td>___ Arm L R</td> <td>___ Knee L R</td> </tr> <tr> <td>___ Neck</td> <td>___ Hand L R</td> <td>___ Foot L R</td> </tr> <tr> <td>___ Chest</td> <td>___ Wrist L R</td> <td>___ Toe(s) L R</td> </tr> <tr> <td>___ Back</td> <td>___ Finger(s) L R</td> <td>___ Other _____</td> </tr> </table>			___ Head/face	___ Shoulder L R	___ Leg L R	___ Eye L R	___ Arm L R	___ Knee L R	___ Neck	___ Hand L R	___ Foot L R	___ Chest	___ Wrist L R	___ Toe(s) L R	___ Back	___ Finger(s) L R	___ Other _____
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___ Back	___ Finger(s) L R	___ Other _____															
Did the incident involve a weapon? <input type="checkbox"/> NA ___ Gun ___ Knife ___ Sword ___ Club ___ Tool ___ Chain ___ Other (please describe): _____																	
Number of employees in the vicinity when the act occurred: _____ List any witnesses to the incident (Name and phone): _____																	
Actions Taken by Healthcare Setting: Security notified _____ Police notified _____ Other: _____																	

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What was the gender of the person(s) who committed the threat/assault? Male Female

Who committed the threat/physical assault? (Do Not List Name)

Stranger Employee
 Personal Relation Other (Describe):
 Patient/Client Room #: _____ (Inpatient)
 Visitor

Please check any risk factors applicable to this incident.

- Working with money
- Working with drugs
- Working alone at worksite
- Working late at night
- Poor lighting outside of worksite
- Other risk factor (describe):

Describe the threat and or assault: (Use additional paper if necessary)

What steps could be taken to avoid a similar incident in the future?
(Use additional paper if necessary)

If the threatened/assaulted victim was an employee, had they received Workplace Violence Prevention Training? Yes No

If yes, what was the date of their training?

Review – Include positive and negative outcomes: (Use additional paper if necessary)

Form completed by:

Date: _____

Print Name: _____ Title: _____

If applicable, Threatened/Assaulted Employee's Signature: _____
(Date)