

New York City Health and Hospitals Corporation

Workplace Violence Incident Reporting Form

Employee Identification				
Last Name		First Name		Employee ID/TKID
Facility		Department		Unit
Workplace Violence Action (select all that apply)				
☐ Stalking ☐ Threat ☐ Physical Contact ☐ Domestic Violence ☐ Other(specify): _____				
Describe the relationship between you the alleged aggressor				
☐ Type 1 (No Connection to Workplace)		☐ Type 2 (Customer/ Client)		☐ Type 3 (Co-Worker) ☐ Type 4 (Personal, Family Member)
Time of day/ shift when incident occurred				
Month/Day/Year		Time of occurrence (approx. If exact is unknown)		Shift occurred
/ /		:	☐ AM ☐ PM	☐ Day ☐ Evening ☐ Night
Location where incident occurred				
Building		Floor	Wing	Room no./Name
Area (hallway, utility closet, etc.)				
Detailed description of the incident, including events leading up to the incident and how the incident ended (do not include any patient identifiers such as name or medical record number etc.)				

Nature and extent of injuries arising from the incident if any have occurred	
Names and job titles of involved employees	
Name or other identifier of other individual(s) involved (other than employees) (do not include any patient identifier such as name or medical record number etc. only use the words such "Patient 1, Patient 2" etc.)	
Names of witnesses (if witness is a patient do not include any patient identifier such as name or medical record number etc. only use the words such "Patient 1, Patient 2" etc.)	

Completed by			
Signature			
Date			☐ Privacy Case
Contact Number:		Work Email:	

Submit the completed form to anyone of the following: Workplace Violence Prevention Coordinator, Hospital Police, Human Resources or Supervisor

Save Form

Print Form