UCONN HEALTH

WORKPLACE VIOLENCE INCIDENT REPORT FORM

Complete this form in conjunction with the UConn Health Workplace Violence Prevention Policy.

PERSON COMPLETING REPORT

Name:	Title:	Department:
Phone:	Email:	Today's Date:

INCIDENT INFORMATION

Date of Incident:	Time of Incident:		
Location of Incident:	Address and town, if off campus:		
Type of Incident:	☐ Physical Assault	☐ Threats	☐ Other (specify)
	☐ Property Damage	☐ Verbal abuse	
Was a weapon involved?	☐ No	☐ Yes (type of weapon)	
Did Law Enforcement respond?	☐ No	☐ Yes (specify Police Department)	
Was Manager/Supervisor present?	☐ No	☐ Yes (name and title)	

INDIVIDUALS INVOLVED (use additional sheets as needed)

Name: Phone:	Title: Email:	☐ Assailant ☐ Victim ☐ Witness
Name: Phone:	Title: Email:	☐ Assailant ☐ Victim ☐ Witness
Name: Phone:	Title: Email:	☐ Assailant ☐ Victim ☐ Witness

ASSAILANT RELATIONSHIP TO VICTIM(S)

☐ Co-worker/current employee	☐ Patient	☐ Contractor/vendor
☐ Former co-worker/employee	☐ Patient's family	☐ Student
☐ Supervisor/Manager	☐ Visitor	☐ Other:

BACKGROUND (If known, check all that may apply)

☐ Consequence of patient condition/disability	☐ Dissatisfied with care/ service	☐ Prior history of violence
☐ Occurred while processing patient information	☐ Employment related	☐ Suspected substance abuse
☐ Occurred while providing direct patient care	☐ Interpersonal conflict	☐ Grief
☐ Other:		

INJURY INFORMATION

☐ Physical injury? ☐ No ☐ Yes If yes, describe:	
☐ Medical care required? ☐ No ☐ Yes If yes, location of treatment:	

DISPOSITION AND FOLLOW UP ACTIONS (Check all that apply)

☐ Situation defused without Police ☐ Police Investigation ☐ Employee Assistance Program contacted ☐ Human Resources notified	☐ Occupational Medicine referral ☐ Supervisor/Manager notified ☐ Patient Assignment Adjusted (per request) ☐ Other, specify:
Disposition of Assailant: ☐ Stayed on premises ☐ Escorted off premises ☐ Left on own ☐ Other, specify:	Restraints used ☐ No ☐ Yes If yes, used by: ☐ Clinical staff ☐ Police Type of restraint: Additional description:

DETAILED DESCRIPTION OF EVENT: (additional relevant information)

Name of person completing report: Date

Submit completed form using the functions to the right, or send as attachment to:
dl-workplaceincidents@uchc.edu

Also, notify and provide your supervisor or manager with a copy of the completed form.

☐

UConn Health Human Resources
Phone: 860.679.2426
Mail Code: 4035
Hours: 8 am – 4:30 pm, M-F

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