ROCKLAND COUNTY
WORKPLACE VIOLENCE INCIDENT REPORT FORM

This form must be used to document any reportable workplace violence incident. Incidents must be reported as soon as possible to the department head or supervisor. The department head or supervisor is responsible for forwarding this completed form to the Hazard Reduction Team.

Name of Alleged Victim: _____

Job Title: _____

Department/Location: _____

Date and Time of Incident: _____

Location of the Incident: _____

Name/Job Title of Individual Completing Report: _____
(if different than reporting individual)

Date Incident Report Completed: _____

List any individuals who may have witnessed this incident:

Witness Name	Witness Job Title (if applicable)	Witness Phone Number

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List any other individuals who may have been involved in this incident (employee or non-employee):

Name of Persons Involved	Role in Incident	Contact Information

Assailant/Perpetrator	✓	Name	Address
Member of the Public	☐		
Employee's Spouse	☐		
Employee's Significant Other	☐		
Employee's Supervisor	☐		
Coworker	☐		
Former Employee	☐		
Other (specify)	☐		

If employed by Rockland County, accused aggressor's job title: _____

Did police respond to the incident? ☐ Yes ☐ No

If yes, name of the Police Department: _____

Was a police report filed? ☐ Yes ☐ No Police Report # _____

Was anyone injured? ☐ Yes ☐ No

If yes, please specify the injuries and the name and location of the facility that provided medical care:

_____

_____

_____

Was there any prior indication that this incident might occur? ☐ Yes ☐ No

Are you aware of any measure that the County has taken to avert this incident from occurring in the future?

☐ Yes ☐ No Please describe: _____

_____

Has the authorized employee representative been notified? ☐ Yes (Date)_____ ☐ No ☐ N/A

Please provide a detailed description of the incident, including what happened immediately prior to the incident and how the incident ended.

If an injury has resulted from the workplace violence incident above, please indicate that an injury has occurred and include a brief description of the injury.

I certify that he above statements are true to the best of the reporter's knowledge, information, and belief.

Signature _____ Date _____

Email the completed form to the Hazard Reduction Team at HRT@co.rockland.ny.us.

FOR INTERNAL USE ONLY (Hazard Reduction Team or Department Head)

Date Received by the Hazard Reduction Team: _____

Indicate the steps that have been taken to mitigate future incidents of a similar nature.

Action Taken	Date Completed

Indicate any steps currently being taken by the County to mitigate future incidents and/or any interim protective measures being taken.

Action in Progress and/or Interim Protective Measures	Estimated Date of Completion

Indicate any other worksites, if applicable, that will require similar action to mitigate future incidents.

_____

_____

Were there any lost workdays? ☐ Yes ☐ No if yes, number of days _____

Has information on crisis counseling services been conveyed and made available? ☐ Yes ☐ No

Has there been crisis counseling since the incident? ☐ Yes ☐ No

_____ _____

Department Head Signature Date

_____ _____

Hazard Reduction Team Signature Date

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