DATA FORM FOR INCIDENTS OF WORKPLACE VIOLENCE
FOR USE BY MEMBER OF THE AGENCY CONSULTING TEAM
ALL FIELDS ARE REQUIRED

CABINET AND AGENCY INFORMATION

Agency Name

Department

Work Address

County

City

INCIDENT INFORMATION

Date of Incident

Time of Incident

Location of Incident

Primary

Secondary

Other

DESCRIPTION OF INCIDENT Select One

Incident Involved Injury Select One

Work-Related Injury Report Filed Select One

Incident Involved Death Select One

Confirm agency has complied with 803 KAR 2:180 KOSH requirements

Law Enforcement Officials Contacted Select One
If yes, explain:

Weapon Involved Select One
If yes, explain:

Was anyone arrested? Select One
If yes, explain:

Were there any witnesses? Select One
If yes, please provide names, if known
1.
2.
3.
4.
5.

OFFENDER INFORMATION

Total number of offenders Select One

Number of Females Select One

Number of Males Select One

Name(s) of offender(s), if known
1.
2.
3.
4.
5.

VICTIM INFORMATION

First Name Middle Initial Last Name

Employee Number

Job Classification

Gender Select One

First Name Middle Initial Last Name

Employee Number

Job Classification

Gender Select One

First Name Middle Initial Last Name

Employee Number

Job Classification

Gender Select One

ANY OTHER RELEVANT DATA

What events led up to this incident?

What, if any, direct services are provided by the employee(s) involved in the incident?

Was there a relationship between the workplace assault victim(s) and the offender(s)?

Name of Person Completing Form
Job Title
Phone Number
Date of Report

COPIES SENT TO:
☐ Agency Workplace Violence Liaison
☐ Agency Human Resource Representative
☐ Safety Officer
☐ KEAP Workplace Violence Liaison Coordinator
☐ Agency Director