



# City of Niagara Falls, New York

P.O. Box 69, Niagara Falls, NY 14302-0069

## EMPLOYEE WORKPLACE VIOLENCE INCIDENT REPORT FORM

Report number: \_\_\_\_\_

Privacy concern case:  Yes  No

EMPLOYEE NAME: \_\_\_\_\_

JOB TITLE: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

DATE OF INCIDENT: \_\_\_\_\_

TIME OF INCIDENT: \_\_\_\_\_

LOCATION OF INCIDENT: \_\_\_\_\_

I. Description of the events just prior to the incident (Include names of individuals involved if known.):

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II. Description of the incident itself (Include names or other identifiers of the individuals, names of any witnesses, and extent of any injuries, etc.):

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(Use additional paper if necessary)

Employee Reporting the Incident: (Sign): \_\_\_\_\_ Date: \_\_\_\_\_

(Print): \_\_\_\_\_

Report Received By: (Sign): \_\_\_\_\_ Date: \_\_\_\_\_

(Print): \_\_\_\_\_ Job Title: \_\_\_\_\_