

NYC DEP WORKPLACE VIOLENCE INCIDENT REPORT

To be completed by involved employee with assistance from either supervisor or EHS personnel as appropriate with input from other parties (BPS, NYPD/Security, etc.) as needed. Sections K, L will be filled out by OEHS. Please return completed form within 7 days following the incident to the Workplace Violence Prevention Coordinator, Persis Luke, Assistant Commissioner, OEHS (lukep@dep.nyc.gov). Attach complainant/witness statement(s) to this form.

Report prepared by:	Date of Submission to OEHS:
Title:	Telephone:

Date of Incident:	Time:
Address/Location of Incident:	

A. Individuals involved in the incident (Note: If there are multiple employees who are complainant, an incident form must be filled out for each Complainant). Does this incident involve a sexual assault or an injury to employee's private parts or reproductive system? If yes, Mark here as a PRIVACY CASE

Complainant's Name:	Respondent's Name:
	Relationship to Employee:
Title (if employee):	Title (if employee):
Bureau and Division:	Bureau and Division/Company (Non-DEP Employee):
Phone:	Phone:
Immediate Supervisor:	Immediate Supervisor:

Respondent's Name:	Respondent's Name:
Relationship to Employee:	Relationship to Employee:
Title (if employee):	Title (if employee):
Bureau and Division/Company (Non-DEP Employee):	Bureau and Division/Company (Non-DEP Employee):
Phone:	Phone:
Immediate Supervisor:	Immediate Supervisor:

B. Was the Complainant/ Respondent involved in any previous incidents involving the same or other DEP employee(s)?

Complainant: Yes No Unknown
Respondent: Yes No Unknown

If Yes, please provide date(s) and a short description:

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C. Apparent Reason for Incident (If known; check all that apply):

<input type="checkbox"/> Personal Conflict	<input type="checkbox"/> Alcohol/drugs in the workplace
<input type="checkbox"/> Family/Domestic Dispute	<input type="checkbox"/> Mental Health Issues
<input type="checkbox"/> Job-Related Conflict	<input type="checkbox"/> Related to issuance of violations/fines to member of the public/business
<input type="checkbox"/> Related to poor performance review	<input type="checkbox"/> Related to service to member of the public at agency facility
<input type="checkbox"/> Related to disciplinary action	<input type="checkbox"/> Street crime/general criminal conduct
<input type="checkbox"/> Altercation involving racial/other EEO-related issues	<input type="checkbox"/> Related to restraint of person in custody
<input type="checkbox"/> Other (specify)	

D. Type of Conduct Engaged in by Respondent (Check all that apply)

Verbal/Written Threat

Communicated directly to Complainant: <input type="checkbox"/> Verbal <input type="checkbox"/> Written Threat <input type="checkbox"/> Mail <input type="checkbox"/> Email
Communicated to third party: <input type="checkbox"/> Verbal <input type="checkbox"/> Written Threat <input type="checkbox"/> Mail <input type="checkbox"/> Email
<input type="checkbox"/> Other (specify):

Repeated Intimidation or Other Threatening Activity

<input type="checkbox"/> Stalking
<input type="checkbox"/> Engaging in actions intended to frighten, coerce, or induce duress
<input type="checkbox"/> Engaging in other threatening behavior Explain:
<input type="checkbox"/> Verbal harassment
<input type="checkbox"/> Showing (but not using) weapon or object intended as a weapon
<input type="checkbox"/> Other (specify)

Assault/Physical Attack

<input type="checkbox"/> Hitting, fighting, pushing, shoving, tripping, poking or body blocking, throwing, etc.
<input type="checkbox"/> Use of gun, knife, or other weapon (specify)
<input type="checkbox"/> Use of object as weapon (specify)
<input type="checkbox"/> Other (specify)

E. Was there a physical injury? (Complainant)

Yes No physical Injury, skip to F

If there was a physical injury, was emergency medical services contacted?

Yes No

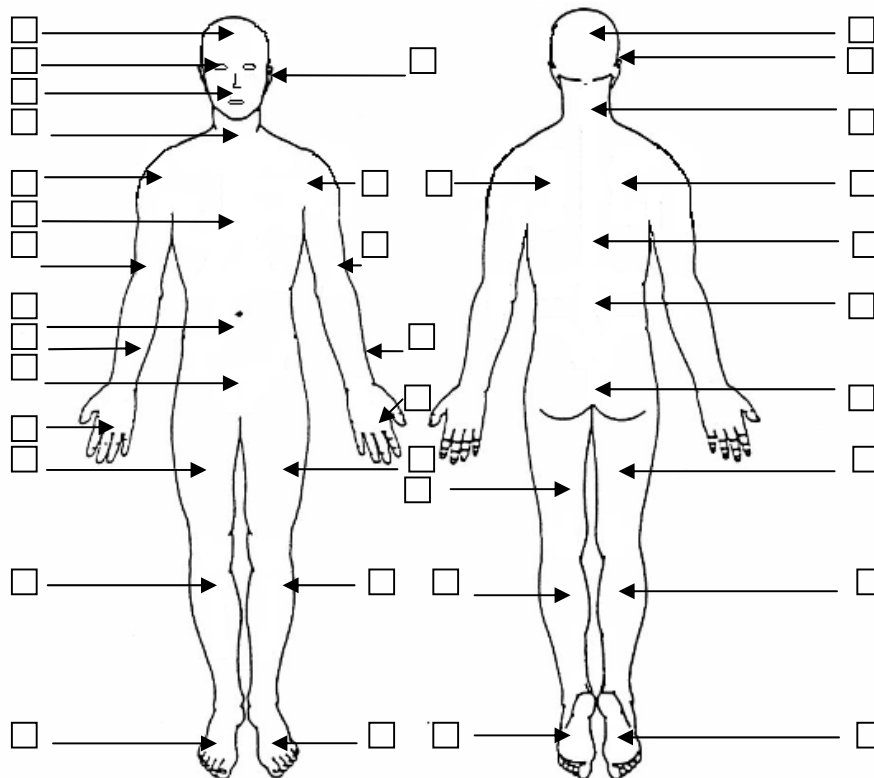
If there was a physical injury, was an injury and illness report completed?

Yes No

Severity of Injury (check only one)

<input type="checkbox"/> Slight (medical attention beyond first aid)	<input type="checkbox"/> Severe (permanent impairment or loss of body part)
<input type="checkbox"/> Minor (1-7 lost workdays non-hospital)	<input type="checkbox"/> Critical (total incapacitation or permanent total disability where employee cannot follow any gainful occupation, or loss of use of both hands, feet or eyes, or loss of combination of any listed)
<input type="checkbox"/> Moderate (8+ lost workdays or admission to hospital for 1-4 days)	
<input type="checkbox"/> Major (admission to hospital 5+ days; major fracture, unconsciousness > 5 minutes; dislocation of major joints; internal organ injury; burns over 10% body)	<input type="checkbox"/> Fatal(from work related mishap or complications arising from the mishap)

Indicate approximate location(s) of injury or injuries on the diagrams below.



F. Provide a brief description of the incident

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G. Was the incident referred to DOI for investigation?

Yes, Date No

H. Was any witness(s) present when the incident occurred?

Yes No (Skip to I)

Witnesses Contact Information:

Name:	Name:
Address:	Address:
Phone:	Phone:

Name:	Name:
Address:	Address:
Phone:	Phone:

I. Initial Response (check all that apply)

<input type="checkbox"/> Situation defused By Whom: How:	<input type="checkbox"/> Law Enforcement called Time called (Approx) Time responded (Approx) Responding Unit/Name: Badge: Report Number:
<input type="checkbox"/> Security called Time called Time responded Responding Unit/Name: Badge:	<input type="checkbox"/> Other (specify)

J. Follow-up Response by Supervisor/Employer (check all that apply)

<input type="checkbox"/> Injury and Illness report filled out	<input type="checkbox"/> Arrest made/other law enforcement action
<input type="checkbox"/> Workplace Violence Prevention Coordinator Notified OEHS A/C (required)	<input type="checkbox"/> Notifications made pursuant to DEP and Bureau Policies on incident reporting.
<input type="checkbox"/> Referral to Employee Assistance Program or other counseling	<input type="checkbox"/> Workers Compensation Forms filled out
<input type="checkbox"/> Disciplinary action initiated	<input type="checkbox"/> Other

K. OEHS Review/Recommendations

L. Recommendations for WPV Prevention Program Review (Should be completed by OEHS with input from BEHS Facility personnel)

What preventive controls were in place at the time of incident?
What preventive controls were not effective and why?
What were the contributing factors/root cause of the incident?
What new controls are required/recommended?
WPV Program changes recommended (OEHS with BEHS input):

Document Control/Review

Case Designation: <input type="checkbox"/> Incident <input type="checkbox"/> Report	OEHS Case Number assigned:
DOI Notification by OEHS: <input type="checkbox"/> No <input type="checkbox"/> Yes, notification date:	
Final Report sent to: <input type="checkbox"/> BPS <input type="checkbox"/> ODC <input type="checkbox"/> BLA <input type="checkbox"/> HRA <input type="checkbox"/> EEO <input type="checkbox"/> BEHS	
Incident Report (excluding witness reports) forwarded to Supervisor to review with Employee <input type="checkbox"/> Yes, date:	
Supervisor or other Bureau designee has communicated the final Incident Report to Employee and Employee received a copy of report <input type="checkbox"/> Yes, confirmation date:	