

WORKPLACE VIOLENCE DATA COLLECTION FORM

Victim's Name (Last, First, Middle)		Victim's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Victim's Home Address (street, city, state, zip)		Victim's Home Phone Number	
Facility employed by:		Victim's Job Title:	
Victim's Work Address: (street, city, state, zip)		Victim's Work Phone Number	
Victim's E-mail address			
Incident Date		Incident Time	
Location of the Incident (street, city, state, zip)			
Work Location – (If different then incident location): (street, city, state, zip)			
Did you file a report with your employer <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Report Completed	
Type of Incident (please check one)			
<input type="checkbox"/> Verbal			
Who or what was threatened?		What was said?	
<input type="checkbox"/> Physical If so describe:			
Were weapons were used, if any: <input type="checkbox"/> Yes <input type="checkbox"/> No		Type of weapon used:	
<input type="checkbox"/> Physical and verbal: <input type="checkbox"/> Yes <input type="checkbox"/> No If so describe:			

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Describe injuries, if any. Clearly identify who received injury.	
Any property damage <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please explain	Police Notified <input type="checkbox"/> Yes <input type="checkbox"/> No If so, was the assailant arrested: <input type="checkbox"/> Yes <input type="checkbox"/> No
Assailant(s) involved in the incident: Name: Unit: Individual's affiliation with the facility: <input type="checkbox"/> Doctor <input type="checkbox"/> Staff <input type="checkbox"/> Visitor <input type="checkbox"/> Personal relation <input type="checkbox"/> Other (please explain)	Immediate Supervisor's name: Has Immediate Supervisor been notified: <input type="checkbox"/> Yes <input type="checkbox"/> No If Supervisor is involved in the incident has the next level of authority been notified: <input type="checkbox"/> Yes <input type="checkbox"/> No Any prior history of violence with any of the individuals involved: Yes_____ or No_____
Who else was present? Name: Department: Address: (street, city, state, zip) Phone Number:	<input type="checkbox"/> Yes <input type="checkbox"/> No If so, When and where: Was it reported: <input type="checkbox"/> Yes <input type="checkbox"/> No If a union member, was the union notified? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you satisfied with your facilities response/actions taken? <input type="checkbox"/> Yes <input type="checkbox"/> No If not why?	
Do you need any other assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Any other information you would like to include:

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Ohio Nurses Association, Attn: Kathleen Morris, 4000 East Main Street, Columbus, OH 43213 | 614-237-5414 | www.ohnurses.org