

CLARK COUNTY WORKPLACE VIOLENCE PROGRAM
OBSERVATION/INCIDENT REPORT

Date of incident _____ Time of incident _____

Employee(s) involved _____ Telephone _____

_____ Telephone _____

_____ Telephone _____

Department/Location of incident _____

Description of incident (continue on other side) _____

Witnesses _____ Telephone _____

_____ Telephone _____

_____ Telephone _____

Was your supervisor notified? _____ Yes _____ No

Supervisor's name _____ Telephone _____

Other actions taken (if any) _____

Comments by employee _____

Name

Signature

Department/Telephone

Date

Send to the Safety Assessment and Assistance Team (FAX: 384-6003) and Employee Relations Administrator (FAX: 382-3748)

cc: Supervisor
Department Head