CITY OF LITTLE ROCK
VIOLENCE IN THE WORKPLACE INCIDENT REPORT FORM

Department: _____ Date/Time of Incident: _____

Physical Address of Incident: _____

Names of Persons Involved: (Include Address and Phone # of Non-City Employees)

1. _____

2. _____

3. _____

(Use reverse side for additional names)

Type of Incident (Check): □Physical Threat □Property Threat □ Physical Assault

Description of Incident: _____

_____

_____

_____

_____

Actions Taken (check):

☐ Police Notified ☐ Human Resources Notified ☐ Disciplinary action(s) pending

☐ Administrative Leave ☐ EAP Referral ☐ Suspended ☐ Terminated

Name (print): _____ Title: _____

Date: _____ Signature: _____

This Incident Report Form must be completed and forwarded to Human Resources Risk Management Division within 24 hours of Incident Occurrence