

WORKPLACE VIOLENCE INCIDENT / THREAT
EMPLOYEE AFTERCARE CHECKLIST

Date of Incident ____/____/____

Name of Employee _____

Date Incident Reported to Management (PS or higher) ____/____/____

Date Incident Reported to Human Resources ____/____/____

Police Contacted Yes ___ No ___ State ___ Local ___

Name of Investigating Officer _____

SEC-1 Completed Yes ___ No ___

If yes, date completed ____/____/____

Copy of both forms sent to Human Resources Yes ___ No ___

On-site State Trooper required* Yes ___ No ___

(AD/Supt. and HR Approval required)

Employee Offered EAP Yes ___ No ___

(Telephone 1-800-676-4357)

If no, please explain why not

Employee "Grounded" from field work* Yes ___ No ___

Employee removed from case* Yes ___ No ___

Employee offered relocation to another office (HR Approval Req'd) Yes ___ No ___

Arrangements made to Follow-up with employee Yes ___ No ___

* Client related threat only

Management Representative Name Date ____/____/____

Management Representative Signature

FORWARD A COPY OF THIS FORM TO HUMAN RESOURCES