INSTRUCTIONS: This form shall be completed for any work-related incident(s) involving SCRS employees, DOR employees or consumers, which occurs at any work location, including in-site

off-site. This report must be submitted within two (2) business days from the date of discovery of the incident.

|  |  |  |
| --- | --- | --- |
| DATE OF INCIDENT | TIME OF INCIDENT | PERSON REPORTING INCIDENT |
| INCIDENT LOCATION (Office Name, Business Name, etc.) | ADDRESS |
| INCIDENT ADDRESS | PHONE NUMBER, INCLUDING AREA CODE |
| CITY, STATE, ZIP CODE  |
| **PART I** (Please complete for all incidents) |
| **TYPE OF INCIDENT** (Check all applicable boxes) |
| * Medical Emergency/Illness/Injury
* Violence
* Assault
* Disruptive/Unprofessional Behavior
* Harassment
* Stalking
* Threat
* Weapon: Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Threatening Gang Activity
* Robbery
 | * Facility
* Assault
* Threat-Bomb, Terrorist, etc.
* Burglary/Theft
* Damage/Destruction of Property
* Fire/Fire Alarm
* Physical Intrusion? If also. Please indicate:
* Controlled building access
* Access to controlled work area
* Trespassing
 |
| * **Other**
 |
| **IDENTIFY ALL POINTS OF CONTACT** (Please Check all Applicable boxes) |
| * CHP/Local Law Enforcement\*
* 911
* Crime in Progress
* Medical Emergency
* Fire Department
 |
| * **Other**
 |
| POLICE REPORT NUMBER (If Applicable) | OFFICER NAME |
| PHONE NUMBER, INCLUDING AREA CODE  | ESTIMATED DOLLAR AMOUNT OF LOSS (If Applicable) |

|  |
| --- |
| **LIST ALL INDIVIDUAL (S) INVOLVED IN THE INCIDENT** (Attach another sheet if necessary) |
| NAME | PHONE NUMBER, including area code |
| * VICTIM
 | * WITNESS
 | * PREPARATOR
 | * SCRS EMPLOYEE
 | * CONSUMER
 | * OTHER
 |
| NAME | PHONE NUMBER, including area code |
| * VICTIM
 | * WITNESS
 | * PREPARATOR
 | * SCRS EMPLOYEE
 | * CONSUMER
 | * OTHER
 |
| NAME | PHONE NUMBER, including area code |
| * VICTIM
 | * WITNESS
 | * PREPARATOR
 | * SCRS EMPLOYEE
 | * CONSUMER
 | * OTHER
 |
| **PART II** (Please complete for all incidents) |
| **INCIDENT INFORMATION N/A YES NO** |
| Do you suspect that this incident involves fraud, embezzlement, or other irregularities? |  |  |  |
| Was sensitive, confidential, or mission-critical information involved?  |  |  |  |
| Were personal computers, systems, and/or applications affected?  |  |  |  |
| Was software or hardware affected by this incident?  |  |  |  |
| Were there injuries? If so, please provide the information below for each injured person. (Attach another sheet if necessary)  |  |  |  |
| NAME |  |  |  |
| BRIEF DISCRIPTION OF INJURIES |  |  |  |
| NAME |
| BRIEF DESCRIPTION OF INJURIES |
|  |
|  |

Have referrals been provided for those needing counseling or assistance?

|  |  |
| --- | --- |
| * Yes
 | * No
 |

SCRS employee, has he/she had Workplace Violence training?

|  |  |
| --- | --- |
| * Yes
 | * No
 |

SCRS employee, has he/she had Workplace Privacy training?

|  |  |  |
| --- | --- | --- |
| * Yes
 | * No
 |   |

SCRS employee, has he/she had Workplace CPR training?

|  |  |
| --- | --- |
| * Yes
 | * No
 |

|  |
| --- |
| **FULLY DESCRIBE INCIDENT**  (Report Facts: Include Who, What, When, Where, and How, History, etc.) (If more space is needed, please attach additional sheets).  |

|  |
| --- |
| **PART III** (Please complete for all incidents) |
| **WHAT ACTION IS BEING TAKEN TO PREVENT SIMILAR INCIDENTS**? Briefly Explain |

|  |  |  |
| --- | --- | --- |
| SUPERVISOR NAME | SIGNATURE | DATE |