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 |