

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

EMPLOYEE REPORT OF WORKPLACE VIOLENCE INCIDENT

OCFS's workplace violence prevention program aims to ensure a workplace free of assaults, homicides and physical violence. OCFS's policy requires affected employees to immediately report workplace violence incidents to supervisory personnel. Section A must be completed and submitted to a supervisor within 24 hours of the incident. A copy of Section A should also be submitted by the employee or supervisor to the Bureau of Labor Relations. (See page 2 for *contact information*.)

(DJJOY ONLY): OCFS-2079 Activity Report for this form or both forms may be used for incidents of youth on staff violence. The supervisor must complete the non-starred sections of **OCFS-4762** and attach the **OCFS-4762** to the employee's **OCFS-2079** if the **OCFS-2079** is used, or complete this entire form if an **OCFS-2079** has not been completed.

Optional: In addition to the above, an employee may also submit this form to the local Health and Safety Committee.

SECTION A. COMPLETED BY: Employee Witness Or Supervisor

NAME (PLEASE PRINT):	TITLE:
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UNIT/LOCATION/FACILITY:	SUPERVISOR:
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If not completed by employee, why?: Chose not to Or Unavailable Or Other

- ★ Check type of incident:**
- An attempt or threat, either verbal or physical, to physically injure an employee.
 - Intentional display of force giving an employee reason to fear or expect bodily harm.
 - Intentional wrongful contact with a person, with or without consent, causing injury.
 - Stalking to cause fear of material harm or to the physical safety or health of an employee when the stalking arose through the course of employment.
 - Some other physical assault or aggressive behavior directed at an employee.

★ LOCATION OF INCIDENT:

★ DATE OF INCIDENT: / /	★ TIME OF INCIDENT: <input type="checkbox"/> AM <input type="checkbox"/> PM
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★ Describe the incident, including names of persons involved, and events leading up to and immediately after the incident: (use additional pages if necessary):

★ Was there an injury to staff? NO YES

★ If yes, describe who was injured, the causes of injury (fist, thrown object, etc.) and a brief description of the injury:

★ Was the Accident Reporting System notified? (1-888-800-0029) NO YES

★ List witnesses to the incident:

★ Was a supervisor notified? NO YES

★ If yes, name of supervisor:

Was law enforcement called? NO YES

If yes, name of law enforcement agency?

LAW ENFORCEMENT CONTACT TELEPHONE #:	LAW ENFORCEMENT CONTACT NAME:
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LAW ENFORCEMENT SIGNATURE:	DATE: / /
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SECTION B. COMPLETED BY NON-INVOLVED SUPERVISOR/MANAGER:	
DATE ORIGINAL NOTIFICATION WAS MADE: / /	TIME: <input type="checkbox"/> AM <input type="checkbox"/> PM
Name of person who was originally notified:	
<input type="checkbox"/> Is a privacy concern case (e.g., an injury or illness to the reproductive organs or resulting from a sexual assault, mental illness or HIV infection)? The employee name must be kept confidential. <input type="checkbox"/> Is this a case of domestic violence (Refer to <i>PPM 2085</i> , "Domestic Violence and the Workplace")?	
Have you reviewed the incident with the employee/person reporting the incident? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Do you agree this is an act of workplace violence? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Is the category of violence correct? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Referred to EAP? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Should additional services be offered to the employee(s)? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If "YES," which services?	
SUPERVISOR / MANAGER SIGNATURE: X	DATE: / /
[Note: Forward to appropriate higher-level management or administrative staff person in the program area.]	
SECTION C. COMPLETED BY MANAGEMENT/ADMINISTRATIVE REPRESENTATIVE:	
OCFS policy requires management/administrative representatives to complete this section of the form and submit it to the Director of the Bureau of Labor Relations.	
Is the incident still under investigation? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Recommended action:	
<input type="checkbox"/> NO <input type="checkbox"/> YES Did you review the Workplace Violence report with the supervisor, including the supervisor's assessment of the incident as Workplace Violence and the supervisor's actions taken to address the incident?	
Additional action taken (including actions to prevent such incidents):	
Completed form is to be sent, as soon as possible, to: <div style="text-align: center;"> Bureau of Labor Relations (OCFS) 52 Washington Street Rensselaer, N.Y., 12144 Fax: 518-486-5514 Phone: 518-486-4240 Second copy in local workplace violence file </div>	