DEPARTMENT OF SOCIAL SERVICES

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 _____

State Police Contacted Yes ___ No ___

Name of Investigating Officer _____

SEC-1 Completed Yes ___ No ___

If yes, date completed _____

WPV-1 Completed by Supervisor Yes ___ No ___

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

On-site State Trooper required* Yes ___ No ___

(RA/Supt. And HR Approval required)

Employee Offered EAP Yes ___ No ___

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 in Region Yes ___ No ___

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

* Client related threat only

_____

Management Representative Signature Date

FORWARD A COPY OF THIS FORM TO HUMAN RESOURCES

Revised 03/2012