BULLYING PREVENTION AND INTERVENTION INCIDENT REPORTING FORM

1. Name of Reporter/Person Filing the Report:

2. Check whether you are the:   Target of the behavior   Reporter (not the target)

3. Check whether you are a:          Patient          Staff member (specify role)  
                                            Family Member  Administrator  Other (specify)

   Your contact information/telephone number:

4. Hospital:       Location/Unit

5. If staff member, state your work site: ______________________________________

   Information about the Incident:

   Name of Target (of behavior):

   Name of Aggressor (Person who engaged in the behavior):

   Date(s) of Incident(s):

   Time When Incident(s) Occurred:

   Location of Incident(s) (Be as specific as possible):

6. Witnesses (List people who saw the incident or have information about it):

   Name: ___________________________  □ Patient □ Staff □ Other ___________________________

   Name: ___________________________  □ Patient □ Staff □ Other ___________________________

   Name: ___________________________  □ Patient □ Staff □ Other ___________________________

7. Describe the details of the incident (including names of people involved, what occurred, and what each person did and said, including specific words used). Please use additional space on back if necessary.

8. Signature of Person Filing this Report: ___________________________ Date: ____________

9. Form Given to: ___________________________ Position: ___________________________ Date: ____________

   Signature: ___________________________ Date Received: ____________