Washington State Department of Social & Health Services

SAFETY AND CLAIMS MANAGEMENT SECTION

Witness Report of Possible Client Assault (Per RCW 72.01.045, RCW 74.04.790)

Submit to local supervisor within one business day of incident.

DATE OF INCIDENT	
TIME OF INCIDENT	☐ AM ☐ PM

1. NAME OF INCIDENT EMPLOYEE / VOLUNTEER (LAST, FIRST, MI)	2. EMPLOYEE ID NUMBER	3. DATE OF REPORT

4. IDENTIFY THE PRECISE LOCATION WHERE THE INCIDENT OCCURRED

FACILITY	BUILDING	ROOM	FURTHER DESCRIPTION OF LOCATION

5. CLIENT NUMBER	**Caution: Other than a client identification number, please do not cite the name, other personal identifiable information, or any health-related information regarding any client on this form or on attached documents.**

	YES	NO
6. Was the location where the incident occurred your regular place of duty?	☐	☐

If no, please explain:

	YES	NO
7. Were you conducting your official duties when the incident occurred?	☐	☐

If yes, please describe what duties you were performing:

If no, please describe what you were doing:

8. Please describe your proximity to the client involved just prior to the incident **(check one)**:

- ☐ a. Within arm's reach of the client.
- ☐ b. Greater than arm's reach, but less than six feet away from the client.
- ☐ c. Greater than six feet, but less than twenty feet away from the client.
- ☐ d. Greater than twenty feet away from the client.
- ☐ e. The client was not in the proximate area.
- ☐ f. Don't know

9. Please describe your activities in the moments leading up to the incident **(check one)**:

- ☐ a. Attention was on my primary duties other than clients.
- ☐ b. Attention was on the client involved in the incident.
- ☐ c. Attention was on several clients, including the client involved in the incident.
- ☐ d. Attention was on several clients, **not** including the client involved in the incident.
- ☐ e. Restraining or attempting to restrain the client alone.
- ☐ f. Helping other staff restrain or attempt to restrain the client.
- ☐ g. Transitioning to or from other locations.
- ☐ h. On my break / meal.
- ☐ i. Other (please describe):

10. Please describe your relative position to the client when the incident occurred **(check one)**:

- ☐ a. Seated facing the client.
- ☐ b. Seated with my side turned to the client.
- ☐ c. Seated with my back turned to the client.
- ☐ d. On my feet facing the client.
- ☐ e. On my feet with my side turned to the client.
- ☐ f. On my feet with my back turned to the client.
- ☐ g. Other (please describe):

11. Which of the following best describes the client's demeanor when the incident occurred **(check one)**:

☐ Happy	☐ Threatened	☐ Agitated
☐ Excited	☐ Fearful	☐ Angry
☐ Playful	☐ Sad	☐ Non-lucid
☐ Other (please describe):		

	YES	NO
12. Are you personally familiar with, or had you been briefed about, the client involved in this incident?	☐	☐
13. If you were familiar or had been briefed about the client involved in this incident, are you aware if the client was previously involved in similar incidents involving staff, other clients, or family members?	☐	☐

14. Please describe fully what you and the injured employee were doing just prior to the incident. (Attach additional pages as needed.)

15. If you know, please describe exactly what the client was doing just prior to the incident. (Attach additional pages as needed.)

16. Please describe any communication between the injured employee and the client just prior to the incident. (Attach additional pages as needed.)

17. Please describe the incident in detail. (Attach additional pages as needed.)

18. NAME OF OTHER EYEWITNESS(ES) TO THE INCIDENT (ATTACH ADDITIONAL PAGE(S) AS NECESSARY)	PHONE NUMBER (AREA CODE)
a.	( )
b.	( )

19. Witness' identification

WITNESS' NAME (PLEASE PRINT)	WORK PHONE NUMBER (AREA CODE) ( )	SUPERVISOR'S NAME
WORK ADDRESS		MAIL STOP
WITNESS' SIGNATURE		

FOR QUESTIONS: Call the Claims Management Section at 1-866-712-3890, or consult the Claims Section website at: http://one.dshs.wa.lcl/FS/Loss/WorkersComp/Pages/default.aspx

General Instructions

This document should be completed by a witness to an alleged assault and provided to the injured employee's supervisor within one (1) business day of the incident.

- Answer all questions as completely as possible. Incomplete forms will be returned for additional information and may delay payment of qualified benefits.
- Be sure to include the injured / ill individual's name and date of the incident on any sheets required to be attached.
- Sign and date the form, and submit all documents to the local chain-of-command. Copies should be forwarded to the local safety office and retained in local files for six years.