



Workplace Concern

Plases DO NOT use ANY Identifiers on this form. Example: Resident/Patient/Client names so confidentiality is not compromised. The purpose of this form is to identify the issues our members are facing in the Workplace.

1) Date: _____ Time: _____ Location: _____

Name: _____ Position: _____

Event: _____

2) Staffing Scheduled			Actual		
RN	_____	RCW	_____	RN	_____
LPN	_____	Other	_____	LPN	_____

3) Were you short staffed at the time of the incident? _____

4) Describe the situation that occurred – please include any pertinent details and contributing information.

5) Was there an incidence of violence(verbal/ physical) or psychological harm

6) Please detail the action taken as it pertains to the situation

7) Was your Manager/Supervisor contacted

Time Contacted: _____

8) Describe the response by Manager/Supervisor

9) Suggest what other alternative measures may have been used

Date yyyy/mm/dd Time --:--

Signature of Member