



## PEPPER SPRAY INCIDENT REPORT

This form must be completed and signed by the employee who is involved in the use of Pepper Spray and turned into their Department Head or supervisor within twenty-four (24) hours.

Please print legibly, provide all the information requested below, attach any documents and statements related to the incident, and sign upon completion.

Employee Name: \_\_\_\_\_

Department: \_\_\_\_\_

Job Title: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_

### INCIDENT INFORMATION

1. Date of Incident: \_\_\_\_\_

2. Time of Incident: \_\_\_\_\_

3. Location of Incident (*Specific Location/Address*)



9. List any individuals who witnessed the incident

Name	Contact [Phone/Email]

The information provided in this incident report is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Department Head/Supervisor:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

Attachments: (Check if included)

Medical Report  Security Footage  Photos  Witness Statements  Other:  
[Specify]

**This form shall be submitted to the HR Department upon completion.**