

Employee Workplace Violence Report

DATE OF INCIDENT: _____

TIME OF INCIDENT: _____

WORKSITE: _____

EMPLOYEE NAME: _____

POSITION: _____

WITNESS(ES): _____

PERPETRATOR Student (specify age): _____ Board Employee Member of Public (specify): _____**TYPE OF INCIDENT**

- | | | | | | |
|--------------------------------------------------------|-----------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------------|------------------------------------------|
| <input type="checkbox"/> Verbal Abuse | <input type="checkbox"/> Verbal Threats | <input type="checkbox"/> Punching | <input type="checkbox"/> Kicking | <input type="checkbox"/> Scratching | <input type="checkbox"/> Stalking |
| <input type="checkbox"/> Pinching | <input type="checkbox"/> Hair Pulling | <input type="checkbox"/> Biting | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Spitting | <input type="checkbox"/> Written Threats |
| <input type="checkbox"/> Pushing and Shoving | <input type="checkbox"/> Smashing/Damaging Property | | | | |
| <input type="checkbox"/> Blocking/Restricting Movement | <input type="checkbox"/> Unwelcome Sexual Contact | | | | |
| <input type="checkbox"/> Other (please specify): _____ | | | | | |

Describe antecedents and the incident.**RESPONSE***Medical attention received Yes NoFirst Aid obtained Yes NoWSIB forms completed Yes NoPolice contacted Yes NoReported to supervisor Yes No

Other (please specify): _____

Has the perpetrator been involved in previous incidents with staff? Yes No Unknown**IMPACT OF INCIDENT ON EMPLOYEE** None Employee felt threatened or frightened Employee physically injured

Other (please specify): _____

SIGNATURE OF EMPLOYEE: _____

DATE: _____

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SUMMARY OF FOLLOW UP ACTION TAKEN

Behaviour Safety Plan (BSP)

 BSP In Place BSP Needs Review BSP Required N/A**Details:**

*As a result of this incident is the employee unable to perform assigned duties?

 Yes No

SIGNATURE OF PRINCIPAL/MANAGER: _____

DATE: _____

COPIES:

Principal/Manager

Superintendent of Schools **OR** Superintendent of Business (for non-school employees)

Reporting Employee

SUPERINTENDENT'S COMMENTS

SIGNATURE OF SUPERINTENDENT: _____

DATE: _____

COPIES:

Principal/Manager

Workplace Violence Prevention and Management (WVPM) Program Administrator (Designated Superintendent)

Health & Safety Officer (if * is checked)

In accordance with Section 20(2) of the Municipal Freedom of Information and Protection of Privacy Act, personal information on this form is being collected under the authority of The Education Act, Section 265(d) and 266 (2, 6, 8, 10); OSR Guideline June 1992; Violence-Free Schools Policy; and will be used for the purpose of establishing a pupil record. Questions regarding this collection should be directed to the Principal.