



# WORKPLACE VIOLENCE INCIDENT REPORT

(APPENDIX 1)

School/Building:	Location of Incident:
Name of the person making the report:	Job title:
Date of Incident:	Time:

### Identify the Victim

Name:	Female <input type="checkbox"/>	Male <input type="checkbox"/>
Employee: <input type="checkbox"/>	Student: <input type="checkbox"/>	Student's parent: <input type="checkbox"/>
Visitor: <input type="checkbox"/> (Specify)	Intruder: <input type="checkbox"/>	Other: <input type="checkbox"/> (Specify)

### Identify the Offender (if possible)

Name:	Female <input type="checkbox"/>	Male <input type="checkbox"/>
Employee: <input type="checkbox"/>	Student: <input type="checkbox"/>	Student's parent: <input type="checkbox"/>
Visitor: <input type="checkbox"/> (Specify)	Intruder: <input type="checkbox"/>	Other: <input type="checkbox"/> (Specify)

### Witnesses




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<p><b>Nature Of Incident:</b> (Check all that apply.)</p> <p>VERBAL:    Abuse <input type="checkbox"/>    Threat <input type="checkbox"/></p> <p>PHYSICAL:    Bite <input type="checkbox"/>    Punch <input type="checkbox"/>    Kick <input type="checkbox"/>    Scratch <input type="checkbox"/>    Pinch <input type="checkbox"/>    Spit <input type="checkbox"/>    Slap <input type="checkbox"/></p> <p style="padding-left: 40px;">Other <input type="checkbox"/> (specify):</p>
<p><b>Injuries Sustained:</b> (Check all that apply.)</p> <p>Arm <input type="checkbox"/>    Hand <input type="checkbox"/>    Face <input type="checkbox"/>    Head <input type="checkbox"/>    Shoulder <input type="checkbox"/>    Neck <input type="checkbox"/>    Chest <input type="checkbox"/>    Back <input type="checkbox"/>    Leg <input type="checkbox"/></p> <p>Foot <input type="checkbox"/>    Other <input type="checkbox"/> (specify):</p> <p><i>(Please ensure that the Board's Accident Report Package is completed and submitted to the Health &amp; Safety Office)</i></p>
<p><b>Weapon(s) Involved:</b>    No <input type="checkbox"/>    Yes <input type="checkbox"/>    If yes, specify:</p>
<p><b>Repeat incident involving the same offender(s):</b>    Yes <input type="checkbox"/>    No <input type="checkbox"/></p>
<p><b>Emergency Services Called:</b>    No <input type="checkbox"/>    Yes <input type="checkbox"/></p> <p>If yes, specify (Police, Fire, Ambulance):</p>
<p><b>Details of the Incident and Follow Up Action Required :</b></p> <p> </p> <p> </p> <p> </p> <p> </p> <p> </p>

Signature of the person making the report \_\_\_\_\_ Date \_\_\_\_\_

Signature of the Superintendent \_\_\_\_\_ Date \_\_\_\_\_

Distribution:    Health and Safety Officer