VIOLENCE INCIDENT REPORT

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| **Employee Information:**  Name: | | Job Title: | |
| --- | --- | --- | --- |
| Shift: | | Department: | |
| **Incident Location:**  Parking Lot    Office     Reception   Cafeteria       Job site specify  Warehouse   Common Area / Grounds       Other (please specify) | | Location City and Address: | |
| **Nature of Incident:**   VERBAL ASSAULT  (Check all that apply) \_\_ Abusive Language                                    \_\_ Intimidation                                    \_\_ Non Specific Threat                                    \_\_ Specific Threat Against                                        Self and/or family  What was said: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                        (nature of threat) | |  PHYSICAL ASSAULT (Check all that apply)  \_\_ Scratched                  \_\_ Head  \_\_ Bitten                          \_\_ Face  \_\_ Kicked                        \_\_ Limbs  \_\_ Punched                     \_\_ Torso/Trunk  \_\_ Struck                         \_\_ Genitals / Breasts  \_\_ Weapon Used   Type of Weapon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Medical Attention / First Aid obtained?**    Yes     No | | Advised of right to consult doctor?    Yes    No | |
| **Reported to Supervisor/Manager?**   Yes      No  Police Called? File #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes     No | | WCB/Forms Completed?   Yes       No | |
| **Assailant Information:**   employee             Visitor /customer          Contractor         Delivery Person       Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_  Is Assailant known to victim?   Yes     No               How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Description:     Male              Female | | | |
| Age: \_\_\_\_\_\_ | Complexion: \_\_\_\_\_\_\_\_\_ | Height: \_\_\_\_\_\_\_ | Weight: \_\_\_\_\_\_\_\_\_\_\_ |
| Name (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **Incident and Injury Information:**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(AM) / (PM) |
| --- |
| Nature of injury:   |  | | --- |   **Witness Information:** |
| Name: | Contact Number |
| 1. | PH.# |
| 2. | PH.# |
| 3. | PH.# |
| **Incident Summary:**  What Happened? (add separate page if necessary)   |  | | --- |   Signature of employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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**To be completed by Manager / Supervisor of victim:**

Are there any other previous violent/aggressive incidents involving this assailant?

🔲 Yes    🔲 No     🔲 Don’t know (Supply details if available)

Are there any other previous violent/aggressive incidents against this employee?

🔲Yes    🔲 No    🔲 Don’t know (Supply details if available)

Any other relevant information:

|  |
| --- |

**To be completed by Occupation Health & Safety Officer:**

1. Health & Safety Representative Involvement required?    🔲 Yes    🔲 No

2. Police action required? 🔲 Yes 🔲 No File #\_\_\_\_\_\_\_\_\_\_

3. Victim Support Services in place:  🔲 Yes    🔲 No      Referred to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Protective Measures Implemented (summary):

|  |
| --- |

5. Report summary concluded: 🔲Yes     🔲No