WORKPLACE VIOLENCE—INCIDENT REPORT

The Occupational Health and Safety Act defines ***Workplace Violence*** *as:*

(a) the exercise of ***physical force*** *by a person against a worker, in a workplace, that causes or could cause physical injury to the worker;*

(b) ***an attempt*** *to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker; or*

(c) a ***statement or behavior*** *that it is reasonable for a worker to interpret as a* ***threat to exercise physical force*** *against the worker, in a workplace, that could cause physical injury to the worker.*

PLEASE USE THIS FORM IF YOU BELIEVE YOU ARE THE VICTIM OF WORKPLACE VIOLENCE AND THE ALLEGED ASSAILANT IS ANOTHER ***TCDSB EMPLOYEE OR VISITOR****. IF THE ASSAILANT IS A STUDENT, PLEASE UTILIZE THE WORKPLACE VIOLENCE HAZARD FORM AND CONSULT WITH YOUR PRINCIPAL /SUPERVISOR AS NECESSARY*

PERSONAL CONTACT INFORMATION

Name: _____ **Date:** _____

(*Victim/Complainant—one form, per employee, per incident)*

** (Optional) Home phone: _____Cell:_____ e-mail: _____

Affiliation:

- ☐ CUPE Local 1280
- ☐ CUPE Local 1328 (SBESS)
- ☐ CUPE Local 1328 (OCT)
- ☐ CUPE Local 1328 (SSSS)
- ☐ CUPE Local 3155 (ILI)
- ☐ CUPE Local 1328: (Adult ESL)
- ☐ CUPE Local 1328: (Adult ESL Nursery)
- ☐ APSSP
- ☐ MAPA (Non-Union)
- ☐ TSU-OECTA
- ☐ TOTL-OECTA
- ☐ TECT-OECTA
- ☐ ETFO-Designated ECE

TYPE OF VIOLENT INCIDENT

- ☐ **Exercise of Physical Force**
- ☐ **Attempt to Exercise Physical Force**
- ☐ **Threat to Exercise Physical Force**

DETAILS OF INCIDENT

School/Site Name & Address: _____

Supervisor's Name: _____

Date & Time of Incident(s):_____

Location of Incident (*Check all that apply*):

- ☐ Classroom
- ☐ Gym
- ☐ Hallway
- ☐ Lab
- ☐ Library
- ☐ Parking Lot
- ☐ Shop
- ☐ Stairs
- ☐ Washroom
- ☐ Yard
- ☐ Other (Specify) _____

Weapon(s) Involved (if any):_____

Are there other victims/complainant(s) (*circle*): Yes No

Others Contacted:

- ☐ Ambulance
- ☐ Police Officer: _____
  Badge Number: _____
  Incident/Crime Report Number: _____
- ☐ Doctor
- ☐ Union
- ☐ Agencies (i.e. CCAS) _____

Repeat incident involving the same assailant(s) (*circle*): Yes No

NOTIFICATION OF INJURY/ACCIDENT INVESTIGATION REPORT (**IF THE ALLEGED ASSAILANT IS YOUR PRINCIPAL/SUPERVISOR, PLEASE FAX *DIRECTLY* TO 416-229-5384. DO NOT FORWARD THIS FORM TO YOUR PRINCIPAL/SUPERVISOR IF HE/SHE IS THE ALLEGED ASSAILANT)

Were you injured? (*circle*) Yes No If injured, have you advised your Principal/Supervisor? Yes No

Are you aware if the Principal/Supervisor completed and faxed the **ACCIDENT INVESTIGATION REPORT ("AIR")** to the Benefits Unit? Yes No

Did you receive medical attention? Yes No

SPECIFICS OF INCIDENT

Describe the incident:

Name(s) of witness(es):

DISTRIBUTION

PRINCIPAL/SUPERVISOR TO FAX THIS COMPLETED INCIDENT REPORT TO: **(416) 512-4980**

[NOTE: IF PRINCIPAL/SUPERVISOR IS ASSAILANT, VICTIM/COMPLAINANT TO FAX COMPLETED INCIDENT REPORT INSTEAD]

A copy of this form will be forwarded to the appropriate Union/Association.

ADDITIONAL NOTE FOR VICTIM/COMPLAINANT:

In certain instances, the Board may offer a facilitated mediation as a voluntary option prior to commencing a formal investigation.

Would you be prepared to engage in a facilitated mediation prior to an investigation commencing? (*circle*) Yes No