

Violence and Harassment Report

Are you reporting an incident of Violence and/or Harassment? Yes No

Employee Details

*Employee Name:

Employee ID	City	Birth Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Job Class / Position	Gender	Hire Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Employee Union		
<input type="text"/>		

Incident Description

*Date of Incident: Time:

Incident Details

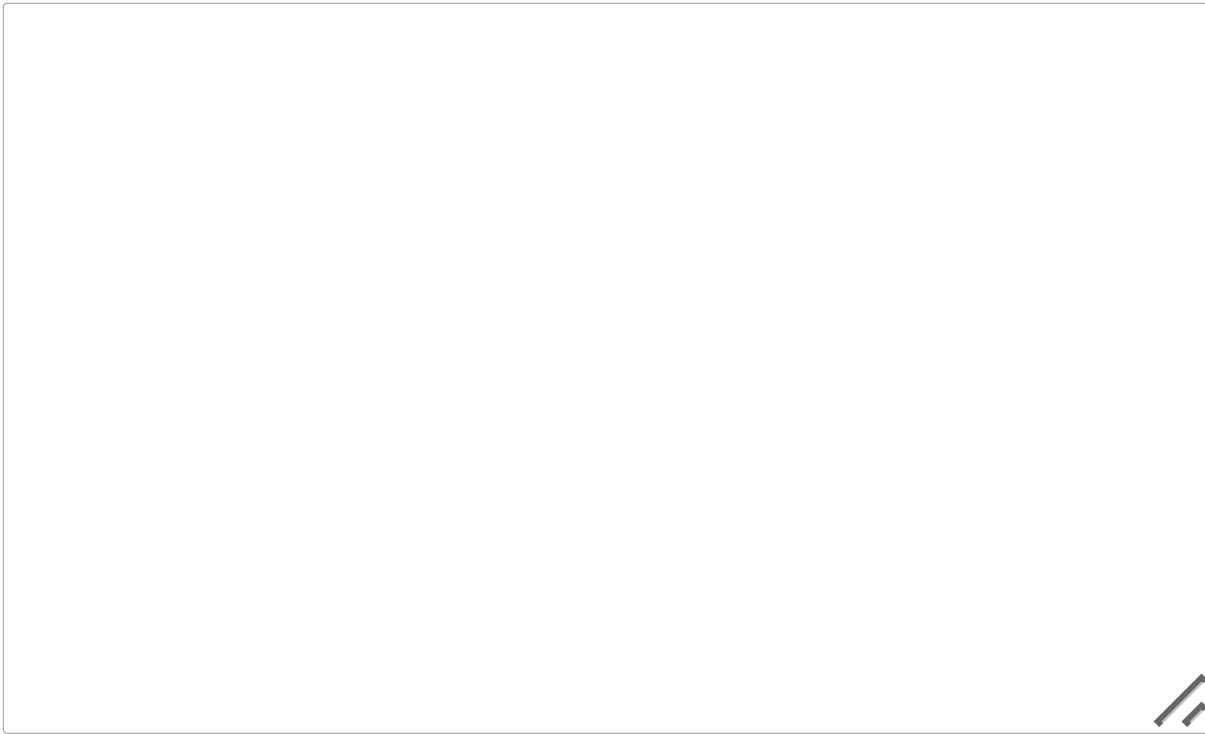
Location where incident occurred

Did the incident result in any of the following? If so, principal must also complete an Accident Investigation Report

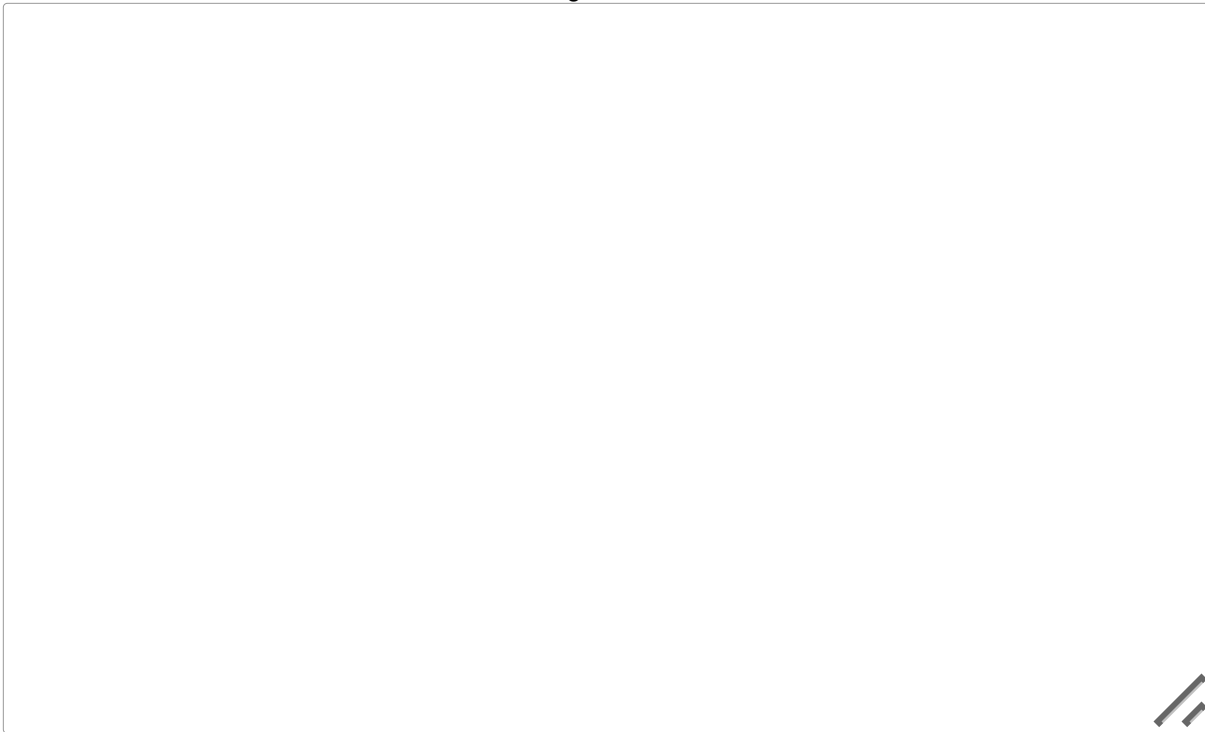
- Health Care - No Lost Time and Medical Treatment Sought (By Medical Practitioner)
- Lost Time - Employee Was Off Work At Least One Day Following Day Of Accident

*What happened to cause this incident?

*What were you doing at the time of this incident?

A large, empty rectangular text box with a thin black border. In the bottom right corner, there is a small icon consisting of two parallel diagonal lines, likely representing a 'done' or 'submit' button.

Provide all additional details that are relevant or significant.

A large, empty rectangular text box with a thin black border. In the bottom right corner, there is a small icon consisting of two parallel diagonal lines, likely representing a 'done' or 'submit' button.

Violence, Harassment Details

Did the situation involve physical violence? Yes No

Did the situation involve harassment? Yes No

Were weapons involved? Yes No Unknown

Is the aggressor a third-party to the company? Yes No

Is the aggressor an employee of the company? Yes No

Is domestic violence a factor in this incident? Yes No

Has the aggressor been involved with any previous violent incidents with staff? Yes No

Aggressor Identification (Name, Address, Age, Height, Role)



Were the Police summoned for this incident? Yes No

Has Government Labour / Regulatory Body been advised? Yes No

Witness Details

Witness(es) of Incident:

Reporting Information

Person who entered this incident report.

First Name:

Last Name:

Telephone Number:

Email Address:

Position/ID/Badge:

Normal Working Hours:

Submit this form to all of the following:

workplace.claims@tcdsb.org

corrado.maltese@tcdsb.org

marta.radic@tcdsb.org

your principal/supervisor (unless they are the aggressor)