

OCCUPATIONAL VIOLENCE

INCIDENT REPORT FORM

This form is to be used by members of the designated work group wishing to report an incident of occupational violence.

Give one copy of the completed form to your health and safety rep and your employer. Keep a copy of the form for your own records.

Section 1 **Contact Details**

Name

Name of person injured

Preferred e-mail contact address

Preferred telephone contact

Date of Incident

Time of incident

Section 2 - Incident Details

Please provide a brief description of the incident, including the names of persons directly involved, including the names of any witnesses.

Did you seek any of the following as a result of the incident?

- First Aid

- Medical Treatment

- Counselling

- None

- Other (please provide a description of assistance sought)

Section 3 – Incident Description.

Tick the boxes to indicate the nature of the injury, if necessary, indicate next to the box the number of times it occurred.

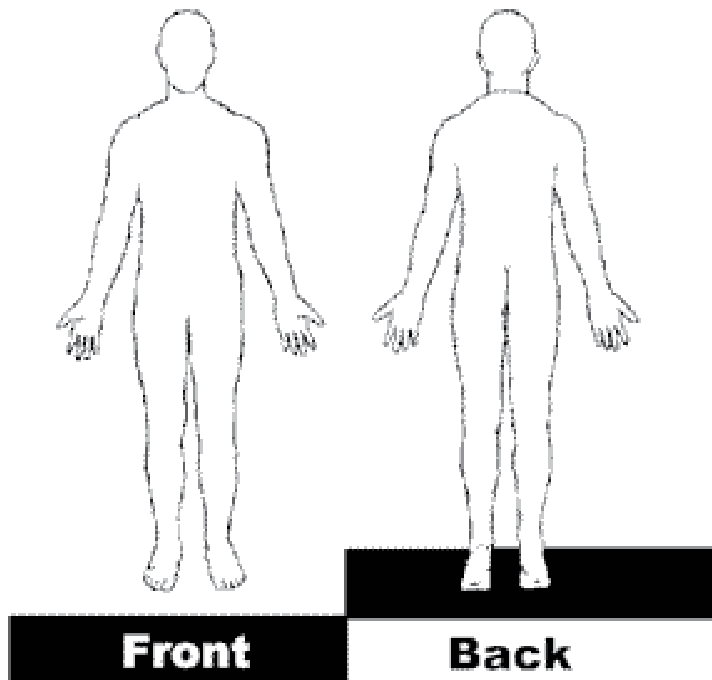
- Punched
- Verbally Threatened
- Grabbed
- Bitten
- Pushed
- Verbally Abused
- Sexual Harassment
- Hit
- Pinched
- Damage to Property
- Knocked Over
- Kicked
- Scratched
- Spat Upon
- Racial Vilification
- Other harassment (provide brief description)

- Stabbed with object (describe object)

- Object thrown (describe object)

- Hit with object (describe object)

Indicate where the injury occurred on the body by means of a circle.



Write the appropriate letter describing the type of injury next to the body area affected, then rate the extent of the injury by circling a number on the scale provided.

		Mild			Severe	
A	Bruising	1	2	3	4	5
B	Cut	1	2	3	4	5
C	Soreness or Sensitivity	1	2	3	4	5
D	Sprain, fracture	1	2	3	4	5

If any of the following symptoms occurred, please rate your level of discomfort by circling a number.

		Mild			Severe	
A	Distress	1	2	3	4	5
B	Anxiety	1	2	3	4	5
C	Insomnia	1	2	3	4	5
D	Vomiting	1	2	3	4	5
E	Diarrhoea	1	2	3	4	5