



AGGRESSIVE INCIDENT REPORTING FORM

SECTION ONE: EMPLOYEE INFORMATION																		
Name:	Affiliation:																	
Employee ID:	<input type="checkbox"/> ETFO <input type="checkbox"/> Elementary Occasional																	
Position:	<input type="checkbox"/> OSSTF <input type="checkbox"/> Secondary Occasional																	
Work Location:	<input type="checkbox"/> CUPE <input type="checkbox"/> AESP																	
Supervisor's Name:	<input type="checkbox"/> OPSEU <input type="checkbox"/> Principal/Vice Principal																	
	<input type="checkbox"/> Instructors																	
Date Reported to Supervisor:																		
SECTION TWO: DETAILS OF INCIDENT (COMPLETE ONE FORM PER DAY IF SAME AGGRESSOR)																		
Repeat incident(s) involving same aggressor: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number of incidents: _____																		
Date of Incident(s):	Site of Incident(s):																	
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Time of Incident(s):</td> <td style="width: 50%; padding: 5px;">Nature of Incident(s): (check all that apply and indicate number of occurrences)</td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> a.m. _____ <input type="checkbox"/> p.m. _____ _____ _____ _____ </td> <td style="padding: 5px;"> Verbal/Non Verbal Aggression <input type="checkbox"/> Shouting _____ <input type="checkbox"/> Swearing _____ <input type="checkbox"/> Threat _____ <input type="checkbox"/> Repeated Non-Compliance _____ Physical Aggression <input type="checkbox"/> Bite _____ <input type="checkbox"/> Punch _____ <input type="checkbox"/> Grab _____ <input type="checkbox"/> Scratch _____ <input type="checkbox"/> Intimidation _____ <input type="checkbox"/> Slap _____ <input type="checkbox"/> Kick _____ <input type="checkbox"/> Spit _____ <input type="checkbox"/> Pinch _____ <input type="checkbox"/> Threat _____ <input type="checkbox"/> Other: _____ </td> </tr> </table>	Time of Incident(s):	Nature of Incident(s): (check all that apply and indicate number of occurrences)	<input type="checkbox"/> a.m. _____ <input type="checkbox"/> p.m. _____ _____ _____ _____	Verbal/Non Verbal Aggression <input type="checkbox"/> Shouting _____ <input type="checkbox"/> Swearing _____ <input type="checkbox"/> Threat _____ <input type="checkbox"/> Repeated Non-Compliance _____ Physical Aggression <input type="checkbox"/> Bite _____ <input type="checkbox"/> Punch _____ <input type="checkbox"/> Grab _____ <input type="checkbox"/> Scratch _____ <input type="checkbox"/> Intimidation _____ <input type="checkbox"/> Slap _____ <input type="checkbox"/> Kick _____ <input type="checkbox"/> Spit _____ <input type="checkbox"/> Pinch _____ <input type="checkbox"/> Threat _____ <input type="checkbox"/> Other: _____	<table style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;">Location of Incident(s): (check all that apply)</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Hallway</td> <td style="padding: 5px;"><input type="checkbox"/> Gym</td> <td style="padding: 5px;"><input type="checkbox"/> Stairs</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Classroom</td> <td style="padding: 5px;"><input type="checkbox"/> Office</td> <td style="padding: 5px;"><input type="checkbox"/> Washroom</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Field Trip</td> <td style="padding: 5px;"><input type="checkbox"/> Parking Lot</td> <td style="padding: 5px;"><input type="checkbox"/> Yard</td> </tr> <tr> <td colspan="2" style="padding: 5px;"><input type="checkbox"/> Other: _____</td> </tr> </table>	Location of Incident(s): (check all that apply)		<input type="checkbox"/> Hallway	<input type="checkbox"/> Gym	<input type="checkbox"/> Stairs	<input type="checkbox"/> Classroom	<input type="checkbox"/> Office	<input type="checkbox"/> Washroom	<input type="checkbox"/> Field Trip	<input type="checkbox"/> Parking Lot	<input type="checkbox"/> Yard	<input type="checkbox"/> Other: _____	
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Aggressor:																		
<input type="checkbox"/> Co-Worker <input type="checkbox"/> Student <input type="checkbox"/> Parent <input type="checkbox"/> Visitor																		
<input type="checkbox"/> Other: _____																		
Weapon(s) Involved: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate item: _____																		
Injuries Sustained: (indicate body part(s)) _____																		
Details of Incident: (please include what lead up to the incident / do not include names)																		



SECTION THREE: COMPLETED BY SUPERVISOR WITH EMPLOYEE

Have the following forms been completed, if applicable?	<input type="checkbox"/> A7100-1 Violent Incident Form <input type="checkbox"/> A1440-1 Physical Restraint Incident Report <input type="checkbox"/> A4002-1 Reporting of Workplace Injury/Illness
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Action Initiated: (check all that apply)	When or What
<input type="checkbox"/> Review IEP and/or Behaviour Management Plan, if applicable	
<input type="checkbox"/> Develop/Review/Revise Safety Plan	
<input type="checkbox"/> Safety Plan Shared with Staff	
<input type="checkbox"/> Modification to Work Environment	
<input type="checkbox"/> Community Agency Support Referral	
<input type="checkbox"/> Police Involvement	
<input type="checkbox"/> Staff Training/In-Service	
<input type="checkbox"/> Personal Protective Equipment	
<input type="checkbox"/> Risk Assessment (in consultation with the Superintendent of Education)	
<input type="checkbox"/> Other	

Has the aggressor been involved in any previous incidents: Yes No

SECTION FOUR: SIGNATURE & DISTRIBUTION

Please print name if someone other than the employee completed this form: _____

Signature:	Date:
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Supervisor Signature:	Date:
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Indicate Work Location Area:	North & East Region	<input type="checkbox"/> Area 1	<input type="checkbox"/> Area 2	
	Central & South Region	<input type="checkbox"/> Area 3A	<input type="checkbox"/> Area 3B	<input type="checkbox"/> Area 4
	South & West Region	<input type="checkbox"/> Area 5	<input type="checkbox"/> Area 6	

Courier the completed form within three (3) working days of the incident to the Human Resource Services Department - Health & Wellness at the Education Centre

Information collected on this form is collected under the authority of the Occupational Health and Safety Act and the Workplace Safety and Insurance Act in accordance with the Municipal Freedom of Information And Protection of Privacy Act. Information will be used for the purpose of staff and student safety. Questions regarding information collected on this form should be referred to Human Resource Services - Health and Wellness at the Education Centre.