



Incident Report

Please take a few minutes to complete this form and return it to your local union Health & Safety Representative. Also, give a copy to management. This will help the Union to accurately record the incidents of **repeated, intentional** bullying that occur. Follow up with management regarding the problem, and to plan strategies to help prevent these problems from recurring.

*If you were assaulted or threatened physical harm, then your incident is workplace violence and must be reported using the workplace violence prevention system in your workplace.

Date of incident: _____ Time of incident: _____

Your Name: _____

Names of other affected workers: _____

Department / Unit: _____

Work location: _____ Wk Phone: _____ Hm: _____

(A/C) (A/C)

Did the incident occur at your work location? Yes No If no, then where? _____

Was it during regular work hours? Yes No

Description of incident: _____

Physical or Psychological Effects: _____

Was medical treatment sought? Yes No Were you hospitalized? Yes No

Did you lose any workdays? Yes No How many days? _____

Was the person who targeted you a: Client -- Co-worker -- Patient -- Supervisor
Other: _____

Were you singled out, or was the incident directed at more than one individual? _____

Did you file a complaint with management? Yes No

Were previous complaints filed? Yes No

Please describe the incident in detail:

Please return completed form to : _____