



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: _____

Work phone: _____ Home phone: _____

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: _____