

# Workplace Violence Reporting Form

**CONFIDENTIAL****Submission Date: (yy/mm/dd):** \_\_\_\_\_

This form assists the University in documenting complaints of violence reported by a worker. Submit the completed form to Occupational Health & Wellness (OHW).

**Fax or Send to (519) 780-1796 / [ohw@uoguelph.ca](mailto:ohw@uoguelph.ca)**

This form will be forwarded to the [Campus Safety Office](#) to initiate an investigation. It will be communicated to Human Resources and the pertaining employee group.

Refer to the Policy and Program on [Violence Prevention in the Workplace](#)

**In an Emergency call extension 2000 or (519) 840-5000 or 911**

**Complainant:**

Full Name: \_\_\_\_\_ Initial: \_\_\_\_\_

**Status:**

☐ Employee ☐ Student ☐ Visitor ☐ Volunteer ☐ Contractor

☐ Other: \_\_\_\_\_

Department: \_\_\_\_\_ Building: \_\_\_\_\_

Phone/Extension: (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

**Employee Group (if applicable):**

☐ UGFA Unit 1 ☐ CUPE 3913 ☐ OSSTF/TARA ☐ PSA  
☐ UGFA Unit 2 ☐ Exempt ☐ UNIFOR ☐ OPSEU  
☐ CUPE 1334 ☐ ONA ☐ UGFSEA ☐ USW

☐ Other (specify): \_\_\_\_\_

**Incident**

Date and Time of Incident: \_\_\_\_\_

Where Did the Incident Occur?

☐ Guelph Campus ☐ Research Station: \_\_\_\_\_

☐ Ridgetown Campus ☐ Other: \_\_\_\_\_

Were the Campus Police/Local Policing Authority notified at the time of the Incident?

☐ Yes ☐ No

Name of Supervisor: \_\_\_\_\_

Have you notified your Supervisor?

☐ Yes☐ No**Injuries (if applicable)**

Was an Injury Incurred?

☐ Yes☐ NoIf **YES**, What Was the Injury? \_\_\_\_\_

Select part of body and indicate Right (R) Left (L), both (B) or Quantity Injured in the box:

☐ Abdomen☐ Fingers☐ Lower Back☐ Upper Arm☐ Ankle☐ Foot☐ Lower Leg☐ Upper Back☐ Chest☐ Hand☐ Neck☐ Upper Leg☐ Ear☐ Head☐ Pelvis☐ Wrist☐ Elbow☐ Hip☐ Shoulder☐ Other: \_\_\_\_\_☐ Eye☐ Knee☐ Teeth☐ Face☐ Lower Arm☐ Toes**Treatment of Injury:**☐ First Aid (OHV or  
Department)☐ Emergency Room☐ Student Health Services☐ Physician /Clinic☐ No Treatment Required

Did you see a Medical Professional?

☐ Yes☐ NoIf **YES**, Date of Visit: \_\_\_\_\_

Name/Address/Phone Number of Medical Profession:

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**Respondent(s):**

Last Name	First Name	Initial

**Witness Information, if any:**

Name	Department	Phone number/Extension

**Description of events**

Provide a thorough description of the events, including who, what, where and when. Note witness names and dates and times of incident(s). If necessary, you may use additional pages:

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Do You Have Any Other Safety Concerns?

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**Signatures**

Reported by: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: (yy/mm/dd) \_\_\_\_\_

The University of Guelph takes every complaint of violence in the workplace very seriously. You can assist in the investigation of the incident(s) by providing as much information and as many details as possible. Information provided about a complaint or incident will not be disclosed except to the extent necessary to protect workers, to investigate the complaint or incident, to take corrective action or as otherwise required by law. By signing this report, you certify that the information herein is factual and accurate to the best of your knowledge.

Report received by: \_\_\_\_\_

Date received: (yy/mm/dd) \_\_\_\_\_