

## D. Violent incident report form

Staff who have been victims of violence at work should complete this report as soon as possible.

### 1. Identifying information

Name	Job title
Shift	Department or section
Location <input type="checkbox"/> Parking lot <input type="checkbox"/> Lobby <input type="checkbox"/> Locker room <input type="checkbox"/> Counter or reception area <input type="checkbox"/> Other (please specify)	
Type of assault <input type="checkbox"/> Verbal <input type="checkbox"/> Threatened <input type="checkbox"/> Struck <input type="checkbox"/> Bitten <input type="checkbox"/> Pushed <input type="checkbox"/> Kicked <input type="checkbox"/> Scratched <input type="checkbox"/> Other (please specify)	
Medical attention or first aid obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No	Advised of right to consult doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No
Investigation conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No	WorkSafeBC forms completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reported to supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Police called? <input type="checkbox"/> Yes <input type="checkbox"/> No
Action taken	

## 2. Assailant

<input type="checkbox"/> Customer <input type="checkbox"/> Patient <input type="checkbox"/> Delivery person <input type="checkbox"/> Ex-employee <input type="checkbox"/> Resident <input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Other (please specify)			
Description <input type="checkbox"/> Male <input type="checkbox"/> Female			
Age	Complexion	Height	Weight
Name (if known)			

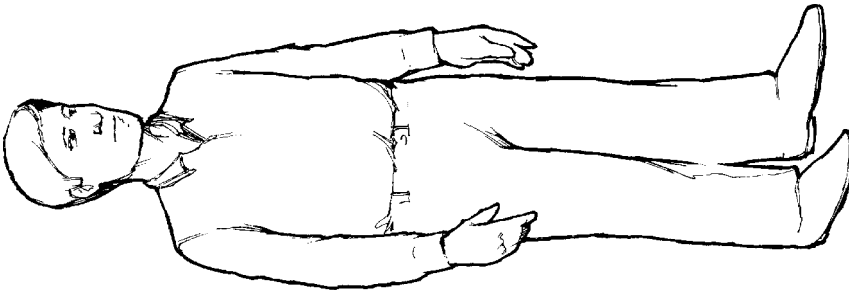
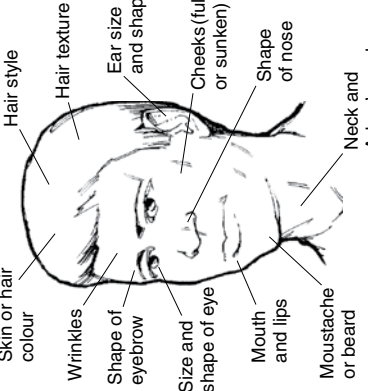
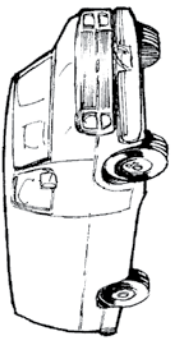
## 3. Incident and injury information

Date of incident	Time  a.m. / p.m.
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## 4. Other information

Was the assailant involved in any previous violent incidents with staff? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any measures in place to prevent a similar incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide any other information you think is relevant.

## E. Suspect and vehicle identification sheet

<p>SEX</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>AGE</p>	<p>HEIGHT</p>	<p>WEIGHT</p>	<p>RACE</p>	<p>Write below specific facial details that you definitely remember.</p>
<p>HAIR (colour and style)</p>	<p><b>General appearance</b></p> 			<p>HAT (colour and type)</p>	<p>What did the suspect say?</p>
<p>EYES (glasses)</p>				<p>COAT</p>	<p>SHIRT/BLOUSE</p>
<p>COMPLEXION</p>	<p>PANTS/SKIRT</p>	<p><b>Facial appearance</b></p> 			
<p>JEWELLERY</p>	<p><b>Vehicle</b></p> 			<p>Colour</p>	
<p>SCARS/MARKS</p>	<p>Direction of travel</p>	<p>Make</p>	<p>Model</p>	<p>Licence number</p>	
<p>TATTOOS</p>	<p>Damage or rust</p>	<p>Bumper sticker</p>	<p>Wheel covers</p>		