EXHIBIT A – SJECCD REPORT OF WORKPLACE VIOLENCE

SJECCD REPORT OF WORKPLACE VIOLENCE

THIS FORM IS TO BE USED BY EMPLOYEES THAT HAVE IDENTIFIED AN INCIDENT, THREAT OR CONCERN RELATED TO WORKPLACE VIOLENCE. THIS FORM BRINGS THE ISSUE TO THE ATTENTION OF THE MANAGEMENT.

IT IS ILLEGAL FOR THE EMPLOYER TO TAKE ACTION AGAINST AN EMPLOYEE FOR MAKING SUCH A REPORT. THE EMPLOYER MUST INVESTIGATE THE REPORT AND EXPLAIN TO EMPLOYEES THE ACTION TAKEN AND ANY SUBSQUENT ACTIONS, AS NECESSARY.

To be completed by the individual investigating the incident. Return completed form within 2 days following the incident to the Director of Human Resources, or your Supervisor, or email wvpp@sjeccd.edu. **Attach witness statements to this form.**

Report submitted by:	Date:
General Description:	Phone:

Date of Incident:	Time:
Address/Location of Incident:	

Individuals involved in the incident (use additional sheet(s) if necessary)

Name:	Name:
☐ Victim or ☐ Assailant	☐ Victim or ☐ Assailant
Job Title:	Job Title:
Department:	Department:
Phone:	Phone:
Immediate Supervisor:	Immediate Supervisor:

Classification of Incident (Select One)

Type 1 ☐	Type 2 ☐	Type 3 ☐	Type 4 ☐
Committed by a person who has no legitimate purpose at the worksite.	Committed by a person who does have a legitimate purpose at the worksite	Committed by a present or former employee, supervisor, or manager.	Committed by a person who does not work at the workplace, but has or is known to have had a relationship with an employee.

Classification of Incident Location (Select One)

☐ At Workplace, Indoors (Please Include Bldg. Name/Room No.)	☐ At Workplace, Outdoors (Please Specify)	☐ Other Area (Please Explain)

Type of Incident

☐ Physical Attack – no weapon/object
☐ Physical Attack – with weapon/object
☐ Threat of physical force and/or threat of use of a weapon/object
☐ Physical Assault - Hitting, fighting, pushing, or shoving
☐ Sexual assault/threat (incl. rape, attempted rape, physical display, or unwanted verbal/physical sexual contact)
☐ Other (specify)

How was the incident communicated? (Check one or more)

☐ Communicated directly to victim	☐ Verbal	☐ Mail	☐ Note	☐ Email
☐ Communicated to another person	☐ Verbal	☐ Mail	☐ Note	☐ Email
☐ Other (specify)				

Initial Response or Follow up Activity: (Check all that apply)

☐ Situation defused	☐ Occupational Medicine notified
☐ Security called	☐ Law Enforcement notified If Yes, Name of Agency and Report Number:
☐ First Aid Received?	☐ Employee Assistance Program Resources Provided?
☐ Other (specify)	

Describe Incident in Detail

Include what happened, where, who was involved, what you heard, saw, etc. Also include the circumstances at time of incident (i.e.: was the employee completing usual job duties, was the area poorly lit, was the work being rushed, was the employee working during a low staffing level, was the employee isolated/alone, was the employee able to get help/assistance, was the employee working in a community setting, was the employee working in an unfamiliar/new location, other – please explain).

List Names of Other Witnesses

Signature Date

Routing – **_For Official Use only_**

Person Receiving Witness Statement Date

Yes	*No*	*Name*	*Signature*	*Date*
☐	☐	Director of Human Resources		
☐	☐	Director of Business Services		
☐	☐	Chief of Police		

Upon completion of investigation, attach a findings/follow-up document to this form.