

Recognize Violence. Report it.



UNSAFE WORKPLACES HURT PATIENTS TOO

ONA VIOLENCE DATA FORM – For Joint Health and Safety Committee Members

Date

Name of affected worker

Email address Phone number

OCCUPATION: RN RPN Other

EMPLOYER

Name

City/Town

FACILITY

Hospital (Emerg ICU/CCU Psych OR Pediatric/Maternity Other)
 Long-Term Care Community Care CCAC Clinic Other

REPORT OF HAZARD

Nature of Violence

Verbal Abuse/Threat Physical Assault Sexual Harassment/Assault
 Attempt to Assault Use of Weapon Other

IMPACT OF VIOLENCE

Physical Injury Mental/Psychological Injury (Critical Lost Time Medical Aid)

SOURCE OF VIOLENCE

Patient Colleague Supervisor Public Domestic relationship Visitor

RESPONSE

MOL involved Orders issued Charges laid Appropriate corrective action by employer

BRIEF DESCRIPTION OF HAZARD AND/OR INCIDENT

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Return this form to your Bargaining Unit President/Labour Relations Officer.

Date

Ontario Nurses' Association

Provincial Office

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