

## Employee Report of Assault\*

(Compliant with Section 25 of the RTA Collective Bargaining Agreement, Protection of Teachers)

ASAR

BENTE

RAP

RTA

**Employee Section**

(Please type or print legibly)

To: \_\_\_\_\_ Date \_\_\_\_\_ School \_\_\_\_\_  
(Principal)

From: \_\_\_\_\_

WORKERS COMPENSATION REPORTS MUST BE COMPLETED FOR ALL WORK RELATED INJURIES. A FULLY COMPLETED WC FORM COPY MUST BE ATTACHED TO THIS REPORT. (THE ORIGINAL SHOULD BE SENT TO EMPLOYEE BENEFITS.) THIS REPORT MUST BE FILED WITHIN 3 BUSINESS DAYS OF THE INCIDENT UNLESS EMPLOYEE IS MEDICALLY UNABLE TO COMPLETE.

Incident: Date \_\_\_\_\_ at \_\_\_\_\_ with \_\_\_\_\_  
(Time) (Student's Name)

\_\_\_\_\_  
Employee's signature

\_\_\_\_\_  
Union Representative/s Signature

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**Principal Section**

To: Superintendent of Schools/His/Her Designee

From: \_\_\_\_\_ Date \_\_\_\_\_  
(Principal)

Check applicable action:  Long-Term Suspension Referral (copy required)  
 In School Suspension/Alternative to Suspension (copy required)  
 Other, please explain \_\_\_\_\_

\_\_\_\_\_  
(Principal's Signature)

Enc. Copy Workers Compensation Form

cc: Union Office

**\* A separate Application for Assault Pay must be completed if loss of time occurs.**

(Rev. 2/2012)

**Application for Assault Pay (AAP)**

**To Be Completed By Employee**  
(Please type or print legibly)

Date Submitted: \_\_\_\_\_

To: Meghan Abate, Director of Labor Relations  
District Designated Representative

From: \_\_\_\_\_  
Bargaining Unit Member

Location/School: \_\_\_\_\_ Date of Assault: \_\_\_\_\_

First date of lost time due to assault \_\_\_\_\_

Expected date of return to work \_\_\_\_\_

Date Employee Report of Assault and Workers Compensation forms were filed with  
Principal/Immediate Supervisor \_\_\_\_\_

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Union Representative's Signature

\_\_\_\_\_  
Date

Required Attachments:     Related Medical Documentation  
    Medical Release

cc: Union Office