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

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

(Rev. 2/2012)