

Harassment Incident Report

School Name: _____

Today's Date: _____

DATE OF INCIDENT	TIME	PLACE
____ / ____ / ____ mm dd yyyy	<input type="checkbox"/> School hours <input type="checkbox"/> Non-school hours	<input type="checkbox"/> On campus <input type="checkbox"/> Off campus – school event <input type="checkbox"/> On school bus <input type="checkbox"/> Directly to & from school
INCIDENT		TYPE
Type of Conduct (check all that apply) <input type="checkbox"/> unwelcome sexual advances <input type="checkbox"/> requests for sexual favors <input type="checkbox"/> verbal conduct – slurs, threats, etc. <input type="checkbox"/> written conduct – notes, letters, etc. <input type="checkbox"/> visual conduct – body language, gestures, intimidation, etc. <input type="checkbox"/> physical conduct – assault, battery, etc. <input type="checkbox"/> sexual assault – unwelcome touching, rape, etc. <input type="checkbox"/> property damage – destruction, graffiti, arson, etc. <input type="checkbox"/> other: _____		Type of Harassment (check all that apply) <input type="checkbox"/> race or ethnicity <input type="checkbox"/> sex <input type="checkbox"/> sexual orientation <input type="checkbox"/> disability <input type="checkbox"/> religion or creed <input type="checkbox"/> national origin or ancestry <input type="checkbox"/> pregnancy or marital status <input type="checkbox"/> parental status <input type="checkbox"/> other: _____
SUSPECT(S)		
Suspect No. 1	Suspect No. 2	Suspect No. 3
<input type="checkbox"/> Student at this school <input type="checkbox"/> Employee of this school <input type="checkbox"/> Other Name: _____	<input type="checkbox"/> Student at this school <input type="checkbox"/> Employee of this school <input type="checkbox"/> Other Name: _____	<input type="checkbox"/> Student at this school <input type="checkbox"/> Employee of this school <input type="checkbox"/> Other Name: _____
Victim	Witness(es)	Resolution
Grade: _____ Gender: _____ Ethnicity: _____ Sexual Orientation: _____ <input type="checkbox"/> Student at this school <input type="checkbox"/> Employee of this school <input type="checkbox"/> Other	Name: _____ Name: _____ Name: _____ Name: _____	Please check one: <input type="checkbox"/> Informal <input type="checkbox"/> Formal <input type="checkbox"/> Complaint dropped <input type="checkbox"/> Other: _____ _____

Name of Victim: _____ **Birth Date:** _____

I certify that the information on this report is true and correct to the best of my knowledge.

signature of person filling out form *print name* *phone no.*

signature of administrator *print name* *phone no.*