DEPARTMENT: Human Resource Division		**POLICY NUMBER:** DPOTMH-APP-HRD-P016 (01)	
TITLE/DESCRIPTION: **MANAGING DISRUPTIVE BEHAVIOR AND WORKPLACE VIOLENCE**			
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PURPOSE:

To ensure patient safety by promoting a safe environment of care, in which all staff treat other staff, medical members, patients, family members of patients and all other employees of the hospital in a respectful, courteous and dignified manner, by preventing behaviors which disrupts efficient operation and delivery of high quality care and threatens to cause harm to others.

DEFINITION:

Aggrieved Party (the Aggrieved), Complainant, or Victim – refers to a person who has been affected by disruptive behavior, attacked, injured or threatened. This may refer to RMCI Covered Personnel, patients or clients, third-party affiliates, or members of the public having experienced such behaviors.

Code Gray – refers to the emergency management response for aggressive, hostile, combative, or potentially combative persons, including verbal abuse and physical battery.

Code Silver – refers to the emergency management response for persons with weapons, active shooter, or hostage situations in the facility.

Discrimination – refers to making derogatory remarks to a person based on their age, family or marital status, physical or mental disability, political or religious beliefs, gender or sexual orientation; drawing attention to these grounds to undermine an individual's role in a professional environment.

Disruptive Behavior – refers to enduring patterns of conduct (behaviors that are uncooperative, contentious or litigious) that disturb the work environment, which may be overt or passive. This includes verbal outbursts to inappropriate actions, such as bullying, harassment, coercion and use of abusive language.

Maximum Tolerance – refers to the application of security measures which exert utmost effort not to harm any personnel or other parties involved.

Mobbing – refers to the submission of several false reports regarding an unpopular or vulnerable individual

Passive or Passive-Aggressive Behavior – refers to the refusal to perform assigned tasks and other reasonable clinical and administrative policies, such as:

- refusing to complete forms, manage records and the like;
- refusing to comply with known and generally accepted practice standards, such that the refusal inhibits staff or other healthcare providers from delivering quality care;

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- interfering with teamwork;
- demonstrating persistent lateness in responding to calls for assistance when on-call or expected to be available;
- quietly exhibiting uncooperative or non-collaborative attitudes with others during routine activities;
- refusing to return phone calls or messages;
- having impatience with questions and reluctance or refusal to answer questions;
- distrusting opinions of others;
- having difficulty in accepting feedback.

Personal Harassment – refers to harassment, such as:

- threatening or coercive actions;
- patronizing and insulting remarks (e.g., about an employee's intelligence);
- berating an individual in the workplace;
- threatening unwarranted discipline or loss of job;
- intimidating gestures, such as slamming doors or throwing objects;
- excluding an employee from the communication loop or withholding information needed to perform work (includes not sending or replying to memos or emails or intentionally not giving notice of meetings).

Physical Aggression – refers to the infliction of physical harm regardless of the level of pain or discomfort.

Physical Threats – refer to inappropriate actions or inactions, such as:

- bullying or intimidation (use of superior strength or influence on force someone to do what one wants);
- throwing or breaking things (damage of corporate or personal property);
- use or threat of unwarranted physical force on patients, family members, staff, and other healthcare providers;
- physical abuse or threatening body language;
- repeated and unjustified complaints about a colleague;
- gossiping and spreading rumors about a colleague.

Respondent (or Assailant) – refers to the person who initiated, brought about, and conducted disruptive behavior.

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Safety – refers to the state in which hazards and conditions leading to physical and psychological harm or injury are controlled in order to preserve the health and well-being of individuals and the community.

Sexual or Physical Harassment – refers to unwelcomed sexual advances, requests for sexual favors or other verbal or physical conduct of sexual nature, such as:

- telling sexist jokes that are clearly offensive or humiliating;
- leering, staring, commenting or gesturing in an obscene manner;
- displaying degrading images of a sexual nature;
- using sexually degrading words to describe a person;
- making degrading remarks toward one's gender or sexual orientation;
- making unwelcome inquiries or comments about a person's sexual life;
- requesting sexual favors;
- pursuing unwanted contact or attention in a persistent manner after a consensual relationship has ended;
- committing sexual assault;
- imposing unwanted touching;
- abusive or threatening verbal comments of a sexual nature.

Verbal Outbursts – refer to verbal release of statements or words that are demeaning or discriminatory, such as:

- profane, obscene, disrespectful, insulting, demeaning or abusive language;
- shaming others for negative outcomes, defamation, or demoralizing comments;
- making sarcastic remarks, condescending language or voice intonation;
- inappropriate arguments with patients, family members, staff or other healthcare providers;
- rudeness or impudence, unwarranted negative comments about another clinician's care (verbal or documented chart notes);
- passing severe judgment or censuring colleagues or staff in front of patients, visitors or other healthcare providers;
- outbursts of anger or engaging in public displays of anger;
- insensitive comments about patients' medical condition, appearance, or situation;
- jokes or non-clinical comments about race, ethnicity, religion, sexual orientation, age,

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physical appearance, socioeconomic or educational status.

Workplace – refers to the entire premises of the Hospital and its immediate surrounding vicinity. It also includes places outside of the Hospital where an employee might be assigned or sent to attend to official business or work-related concerns.

Workplace Harassment – refers to an offensive or unwelcome comment and action that serves no purpose in the workplace. It can be a single event or series of incidents that belittle, degrade, or shame the person, such as verbal or written discrimination; sexual and personal harassment; and retaliation against an individual.

Workplace Violence – refers to any action, incident or behavior that departs from reasonable conduct, or any behavior that may be construed as disruptive behavior, in which a person is assaulted, threatened, harmed, injured as a direct result of physical aggression by an employee against another person, who may be a third party (patient, visitor, guest, etc.) or a co-employee. This may not be limited to staff with authority, influence, or moral ascendancy. A separate Non-Discrimination and Anti-Harassment Policy in the Workplace (DPOTMH-HW-P35) also applies.

RESPONSIBILITY:

Human Resources, Administrative Investigation Unit (AIU) or Committee, Security, Client Relations, Patient Experience, All Directors, Officers, Employees, and Medical Consultants (collectively "Covered Personnel") acting on behalf of the Company and its subsidiaries.

POLICY:

The Hospital undertakes all means in promoting and sustaining a culture of safety. Thus, the Hospital emphasizes zero tolerance against disruptive behavior in the workplace. Acts of violence and disruptive behavior within the workplace are considered as acts of serious misconduct, which are grounds for sanctions in accordance with the provisions of the Labor Code of the Philippines, the Hospital's Policy on Handling Disciplinary Action (DPOTMH-MPP-ER/LR-P011-(01)), Code of Professional Conduct (DPOTMH-APP-HRD-P003-(01)) and the RMCI Code of Discipline Handbook.

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1. **Potential Risk**
   - 1.1. Disruptive behavior may arise from misunderstanding and bottled-up concerns. Therefore, the Hospital encourages all employees to raise their concerns to their Immediate Superior or Human Resources and may be referred to professional help if necessary.
   - 1.2. In the case of Code of Gray activation, respective security measures will apply. (See DPOTMH-HW-P13-S09: Code Gray for more details)
   - 1.3. To reduce the risk of disruptive behavior, the hospital MANCOM, through its Occupational Safety and Health Committee for employees, Quality Management and Patient Safety for clients/patients, and HR-ER/LR, continuously identifies areas for potential disruptive behavior. Current areas that are identified are the emergency department, patient care areas (i.e., patient rooms and patient hallways), and business office areas such as cashiering, admission, and billing.
   - 1.4. The Hospital's Management Committee through Human Resources, Compliance Office, and other support departments and committees *(e.g., OSH Committee),* shall also:
     - 1.4.1. Provide a multi-disciplinary forum to guide staff in understanding the applicable compliance policies that are followed. The committee also ensures that the Hospital's Code of Discipline and Code of Professional Conduct are strictly followed, and that all reported compliance reports are monitored and evaluated fairly and properly.
     - 1.4.2. Ensure that patient care is provided within business, financial, ethical, and legal norms.
     - 1.4.3. Ensure non-discrimination in employment practices and provision of patient care in the context of the cultural and regulatory norms of the county.
     - 1.4.4. Review the Hospital's Code of Discipline and Code of Professional Conduct and the compliance policies annually or as the need arises.
     - 1.4.5. Establish a mechanism by which healthcare practitioners and other staff may raise ethical concerns without fear of retribution.
     - 1.4.6. Provide oversight on professional ethical issues.
     - 1.4.7. Provide support in identifying and addressing ethical concerns and ensure that the appropriate resources and training are available to the staff.
     - 1.4.8. Provide an effective and timely resolution to ethical conflicts that may arise.

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2. Preventive Measures

2.1. A short discussion on culture safety is included in the Hospital Safety Program, emphasizing the importance of maintaining a safe and healthy workplace, which is a core value upheld by the Hospital.

2.2. Education is provided on policies that promote a culture of safety, including but not limited to the provisions outlined in the Code of Discipline and the Code of Professional Conduct.

2.3. Leadership rounds are conducted to raise awareness about the importance of safety programs throughout the Hospital.

2.4. Safety is the responsibility of all hospital personnel. Therefore, vigilance and awareness of any potential disruptive behavior are crucial in maintaining a safe environment.

2.5. Educational campaigns and reminders about how to interact with hospital personnel are displayed in designated areas to address and prevent disruptive behavior.

3. Reporting of Disruptive Behavior

3.1. Any form of disruptive behavior should be escalated to the Security Office or Immediate Superior, whoever is immediately accessible or available.

3.2. Following an incident of disruptive behavior, the Aggrieved or any Witness may initially report the incident verbally to the Immediate Superior so action can be taken in a timely manner. The report must contain the following: - *NCR*

3.2.1. Name of the Reporter (Aggrieved/Complainant or Witness);

3.2.2. Name of the Person whom the complaint is being made (Respondent);

3.2.3. Date, time, and location of the incident;

3.2.4. Brief description of the incident (by answering the 5W1H questions and narrating the facts);

3.2.5. Name of anyone else who saw the incident (Other Witnesses);

3.2.6. Supporting evidence (CCTV Footages, Anecdotal Reports, Videos and Pictures for Medico-Legal Cases)

3.3. An Incident Report (IR) shall be submitted by the Aggrieved, the Witness, or the Immediate Superior to Human Resources Employee and Labor Relations, within 24 hours of the incident.

3.3.1. If the incident involves patient safety concerns, a Non-Conformity Report (NCR)

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Form may be used and submitted to the Total Quality Division Office. (See DPOTMH-APP-TQD-P035-(02): Non-Conformity Report for more details.)

3.3.2. If the incident involves serious corporate misconduct, such as fraud and corruption or requires the confidentiality of the Reporter, a Whistleblowing Report (WBR) Form may also be used and submitted to the Compliance Office. (See DPOTMH-HW-P27-(01): Whistle Blowing Policy for more details.)

3.3.3. If the Reporter does not have access to the above forms or platforms or is not an employee of the Hospital (e.g., patients, folks), written letters detailing the incident may be used.

3.4. The following Accountable Units or parties must be included in the tagging of the report:

For Incidents Involving:	Accountable Units to Include
Patients, Folks, Visitors, and Other External Stakeholders	Corporate Communications and Client Relations, and Patient Experience
RMCI Directors, Officers, Employees	Human Resources Employee and Labor Relations
Medical Consultants, Residents, Post-Graduate Interns (PGIs)	Office of the Medical Director and Medical Affairs
Third-Party Contractors, Service Providers, and Affiliates (Student Interns)	RMCI Contract Owners and Third-Party Authorized Representative
Outsourced Personnel	Outsourced Team Leader and RMCI Facilities Management

3.5. All reports should be confidential. All parties are expected to respect and maintain the confidentiality of the process and not to divulge the details of the investigation to anyone.

3.6. Individuals who report incidents of disruptive behavior shall be protected from reprisal, discrimination or any form of sanctions or prejudice due to reporting.

3.7. All personnel must also be free from retribution.

3.8. Hospital Personnel who have no access to the Communicator E-Library for the forms may directly submit a letter that includes the details indicated in 3.2 to the Accountable Units as specified in 3.4.

3.9. Incidents may also be reported through the Whistleblowing Platform (ProActive Hotline: proactivehotline.grantthorntonsolutions.ph) or e-mail (compliance@rivermedcenter.net).

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(Whistleblowing Policy)

4. Handling of Incidents

4.1. The Hospital does not tolerate any form of disruptive behavior. Acts of violence and disruptive behavior within the workplace are considered as acts of serious misconduct, which are grounds for termination of employment. Thus, all Hospital Personnel included in the incident will be subjected to appropriate internal disciplinary investigation (and sanctions, if any); the procedure for which will be in accordance with the provisions of the Labor Code of the Philippines and Hospital's Policy on Handling Disciplinary Action.

4.2. Workplace violence outside the Hospital premises may be covered by this policy on a case-to-case basis only if the personnel are on official business or during attendance at any meeting or official event sanctioned by the Hospital.

4.3. As a general rule, Security Personnel must exercise maximum tolerance in handling any incidents of workplace violence. The Security Personnel will ensure that all Hospital personnel are kept safe from harm.

4.4. The Accountable Unit should be notified by Security once there is entry of a client or guest with a history of reported disruptive behavior. A list of blacklisted individuals shall be endorsed and monitored by the Security Specialist.

4.5. For verbal outburst, verbal threats, passive behavior and discrimination, the following will be observed:

4.5.1. Immediate Action – Activation of Code Gray (Verbal Abuse) by the Aggrieved, Witness, or Unit Head. (See DPOTMH-HW-P13-S09: Code Gray for more details)

4.5.1.1. Security will immediately remove the Respondent from the area.

4.5.1.2. The Department Manager, Unit Head, or Immediate Superior, together with Security, will guide the Respondent to a private space.

4.5.1.3. The Accountable Units will assist in attempts to verbally de-escalate the Respondent.

4.5.1.4. The Accountable Units will call in assistance to take over, if necessary.

4.5.1.5. The Accountable Units will add distance or barriers between the Aggrieved and the Respondent.

4.5.2. Accountability

4.5.2.1. One or two Security Personnel (with Security Supervisor);

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4.5.2.2. Supervisor or Department Manager of the area where the disruptive behavior happened (Accountable Unit);
4.5.2.3. Client Relations or Patient Experience (for involved external Customers)
4.5.2.4. Human Resources (for involved Employees)
4.5.2.5. Medical Affairs or Office of the Medical Director (for involved Doctors)
4.5.2.6. Contract Owner/Outsourced Team Leaders (for third party/outsourced personnel)

4.5.3. Action – The personnel accountable will try to talk to the Respondent, assess the situation and try to resolve the concern.

4.5.4. Elevation – Should the Respondent choose to continue to exhibit disruptive behavior, Security will take over the situation and try to use verbal communication and officer-presence gesture to resolve the situation. The Security will explain to the Respondent that they have the right to file a formal complaint about their concern.

4.5.5. Police Assistance – Security will seek assistance from the nearest PNP station if disruptive behavior continues. Should the Aggrieved be an Employee and will choose to file for blotter, the Employee will be assisted by Security to the nearest PNP or barangay for personal protection.

4.5.6. Verbal Outburst via telephone call should be reported to the Accountable Unit to ensure that the complaint will be investigated and raised accordingly.

4.6. For harassments, physical threats and physical aggression or violence, the following will be observed:

4.6.1. Immediate Action – Activation of Code Gray (Physical Battery) by the Aggrieved, Witness, or Unit Head. (See DPOTMH-HW-P13-S09: Code Gray for more details)
4.6.1.1. Security will immediately remove the Respondent from the area.
4.6.1.2. The Department Manager, Unit Head, or Immediate Superior, together with Security, will guide the Respondent to a private space.
4.6.1.3. The Accountable Units will assist in protecting the Aggrieved and Witnesses present by stopping or deflecting the attacks of the Respondent.
4.6.1.4. The Accountable Units will create diversions by putting distance or barriers between the Aggrieved and Respondent.

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4.6.1.5. The Accountable Units will provide medical assistance, if needed.

4.6.2. Accountability

4.6.2.1. One or two Security Personnel (with Security Supervisor);

4.6.2.2. Supervisor or Department Manager of the area where the disruptive behavior happened (Accountable Unit);

4.6.2.3. Client Relations or Patient Experience (for involved external customers)

4.6.2.4. Human Resource (for involved Employees);

4.6.2.5. Medical Affairs or Office of the Medical Director (for involved Doctors);

4.6.2.6. Contract Owner/Outsourced Team Leader (for Third Party or Outsourced Personnel)

4.6.3. Action – Security will immediately use hold and restraint and try to talk to the Respondent to resolve the situation. The Accountable Unit and Management will ensure that the safety of the staff will be prioritized.

4.6.4. Elevation – Security will use temporary incapacitation or deadly force if necessary.

4.6.5. Police Assistance – Security will immediately seek assistance from the nearest PNP station. Should be Aggrieved be an Employee and will choose to file for blotter, the Employee will be assisted by Security to the nearest PNP or barangay for personal protection.

4.7. Should a staff member be harmed by an external Customer, the Hospital shall do all necessary means to ensure that the staff is immediately removed from the area of the incident and assisted by Security, Human Resources, and their Immediate Superior. Client Relations will ensure that the attention of the external customer will be called. Contract Owner or Outsourced Team Leader will relay the incident to their company and do the necessary investigation.

4.8. Should the incident happen beyond office hours or during holidays or weekends, the following will handle the situation:

4.8.1. Security;

4.8.2. Highest ranking officer in the unit or assigned OIC of the shift;

4.8.3. Shift Supervisor

4.9. For uncontrolled incidents and those that involve outside parties, the Security Office may opt for Barangay or Police assistance, whichever is applicable and available, during the incident. Thereafter, the Security Office must report the same to the police authorities,

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especially when physical harm was inflicted by any of the parties to the other, in accordance with appropriate DOH/PNP regulations.

5. Review of Incident Report

5.1. The Accountable Units, in coordination with the Administrative Investigation Unit (AIU), shall accomplish the following based on the submitted Incident Report as soon as possible:

5.1.1. Review the history of the event reported, whether the incident was a new or chronic behavior as related by the Aggrieved or Witness; and

5.1.2. Explore the allegation further by verifying when, where, why, and how the incident occurred.

5.2. The turnaround time for the review of the Incident Report shall be **five (5) working days**, which can be extended as necessary with proper justification.

5.3. Moreover, Root Cause Analyses (RCAs) may be conducted with the Total Quality Division and the Accountable Unit if certain patient care procedures contributed to the incident.

6. Investigation of Incident

6.1. The Medical Affairs (through the Office of the Medical Director or Chief Medical Officer, in consultation with the Clinical Department Chair), Client Relations, Unit Head, or the Administrative Investigation Unit (AIU) in charge of investigating the report should be able to check the following elements:

6.1.1. Corroborating statements and information from more than one witness, and if possible, documenting witness statements;

6.1.2. Recognition of what information should remain confidential;

6.1.3. Accepting only objective accounts of witnessed behavior, not opinion or conjecture;

6.1.4. Careful evaluation of the context for the behavior;

6.1.5. Consideration of possible mitigating factors such as cultural issues, single event frustration and chronic system provocation;

6.1.6. Determining if the effort is based on false information, possible submitted by a jealous or angry member of the healthcare team, whereby in such case, a false report would be considered disruptive behavior, and the Reporter would face an

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appropriate sanction for this action;

6.1.7. Considering the possibility of mobbing.

6.2. As a general rule during investigations involving Customer-Employee or Physician-Employee incidents, the Aggrieved and the Respondent may not be required to meet in person to prevent the escalation of the conflict.

6.3. Reports, including but not limited to whistleblowing reports related to Patient Safety and Compliance, may be elevated to the Hospital's Management Committee as assessed and reviewed by Human Resources and the Compliance Office.

7. Assessment of the Respondent

7.1. For house officers, fellows, residents and consultants, the Medical Affairs (through the Office of the Medical Director or Chief Medical Officer, in consultation with the Clinical Department Chair) shall assess the Respondent, validate the incident, and make a report.

7.1.1. The Medical Affairs or Office of the Medical Director shall also initiate investigations and recommendations, and coordinate these with the Administrative Investigation Unit and Management Committee.

7.2. For employees, the Unit Head shall assess the Respondent, validate the incident, and make a report to the Human Resources Employee and Labor Relations.

7.2.1. The initial investigation of the Unit Head may be raised to Human Resources for proper facilitation and possible disciplinary case.

7.3. For external customers and guests, the Client Relations Office initiates investigations and recommendations, and coordinates these with the Administrative Investigation Unit and Management Committee.

7.4. For third parties or outsourced personnel, the Third-Party Authorized Representative or Outsourced Team Leader initiates investigations and recommendations based on their company rules and guidelines.

8. Resolution of the Incident

8.1. The monitoring and tracking of Incident Reports shall be initiated by the Accountable Units within which the incident occurred, until these are properly endorsed to the Administrative Investigation Unit, who shall present the conducted investigation to the Management Committee for decision and resolution.

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8.2. For house officers, fellows, residents and consultants, disciplinary steps or legal actions will be determined by the Management Committee, through the Office of the Medical Director or Chief Medical Officer, in consultation with the Clinical Department Chair.

8.3. For employees, disciplinary steps or legal actions will be determined by the Management Committee, in coordination with Human Resources and the relevant Accountable Units.

8.4. All reports of disruptive behavior, whether minor or major, will be include in the 201 files of the subject of complaints and pattern of disruptive behavior will merit a range of sanctions from written reprimand to suspension and revocation of clinical privileges or dismissal from the employment. Such actions may be taken after due process as prescribed by all relevant policies, procedures, rules and regulations governing the Professional Staff or the Employee's Code of Discipline.

8.5. Feedback will be given to the Aggrieved regarding the interventions made. This will be given by accountable units as specified.

8.6. For external customers, guests, outsourced personnel, and third parties, the Client Relations Office and the outsourced team leader, company representatives, or contract owner will ensure that the customer or outsourced personnel is informed that disruptive behavior and harassment will not be tolerated within the Hospital premises respectively. Blacklisting and lawsuits may be exacted by the Hospital as some remedies to the incident.

9. Debriefing

9.1. Immediate first aid will be given to both parties (Aggrieved and Respondent) who may need medical assistance due to workplace violence.

9.2. Succeeding medical attention for Hospital Personnel may be shouldered by the Hospital, if it was proven that the incident was not initiated or provoked by the Employee concerned. *Refer to policy on Employee Health Services*

9.3. Hospital Personnel who may require debriefing may be endorsed to Human Resource for assistance. *Refer to policy on Employee Health Services (Wellness Clinic)*

9.4. Should the Employee need necessary rest or change of patient, it may be allowed for a specific period to ensure fitness of work of staff. The employee or patient (the Aggrieved) may also be escorted by Security to the nearest police station to file for blotter, if necessary or as requested.

DEPARTMENT: Human Resource Division		**POLICY NUMBER:** DPOTMH-APP-HRD-P016 (01)	
TITLE/DESCRIPTION: **MANAGING DISRUPTIVE BEHAVIOR AND WORKPLACE VIOLENCE**			
EFFECTIVE DATE: May 15, 2025	**REVISION DUE:** May 14, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 14 of 16
APPLIES TO: All Hospital employees, staff, Third Party/ Outsourced personnel, accredited doctors and consultants, performing their duties within their assigned workplace and/or during Official Business and company event		**POLICY TYPE:** Administrative	

10. Legal Actions

10.1. The Hospital will be excluded in any personal or individual lawsuit or proceedings arising out of or relating to Disruptive Behavior. If the Respondent is an Employee, the Hospital will not be liable for the Respondent's acts and the said Employee agrees to indemnify the Hospital, if it is held solidarity liable with the Employee by a third party or a co-employee.

10.2. Employees may take any legal action against the Respondent at their own effort and discretion. Such actions should not cause any corporate embarrassment or public scandal for the Hospital.

10.3. If the act of violence constitutes a crime, the Hospital will cooperate in the prosecution thereof, in addition to its own investigation of such an act as an administrative disciplinary case.

10.4. As a rule, to safeguard Employees and Doctors, request for sensitive personal information, including but not limited to Employee or Doctor's name, will require a formal written letter, indicating the purpose of the request for proper reference and documentation, in compliance with the Data Privacy Act of 2012.

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PROCEDURES (SOP): N/A

WORK INSTRUCTION: N/A

WORKFLOW: N/A

FORMS: N/A

EQUIPMENT: N/A

REFERENCES:

1. Asian Hospital and Medical Center: PL-HRD-056 Managing Disruptive Behavior and Workplace Violence
2. DPOTMH-APP-HRD-P003-(01): Code of Professional Conduct
3. DPOTMH Code of Discipline Handbook (HR ER/LR-S2018)
4. DPOTMH-HW-P27-(01): Whistleblowing Policy
5. DPOTMH-MPP-ER/LR-P011-(01): Handling Disciplinary Action
6. DPOTMH-HW-P35: Non-Discrimination and Anti-Harassment Policy in the Workplace
7. RMCI OSH Policy
8. RMCI Risk Management
9. RMCI NCR

RIVERSIDE MEDICAL CENTER, INC.

DR. PABLO O. TORRE MEMORIAL HOSPITAL

METRO PACIFIC HEALTH
THE HEART OF FILIPINO HEALTHCARE

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TQD

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