Incident/Performance Report

Use this form to record any incidents, work place performance or work place behavior problems. In situations where the circumstances are severe enough to warrant a post-accident or a for-cause drug test this document must be completed within 24 hours of the time the incident occurred and the testing was initiated.

Employee's name ________________________________ Date of incident: _______________

Time of incident: _____________ Location of incident______________________________

Describe the incident in detail: ____

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If additional space is needed please use the back of the page.

Please list all witnesses to the behavior or incident.

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Did you discuss the incident and/or behavior with the employee? Yes: _______ No: _________

Remarks: ____

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Signature of Employee __________________________________ Date ______________

Signature of Supervisor __________________________________ Date ______________

Signature of Supervisor __________________________________ Date ______________

Behavioral Observation Checklist

Name of observed employee:____

Date____________ Job Site:____

Name of Supervisor:____

Witness:____

Check all those indicators or cues observed in the work place.

Appearance

glassy eyes	yes ☐	no ☐
blank stare	yes ☐	no ☐
bloodshot eyes	yes ☐	no ☐
flushed face	yes ☐	no ☐
alcohol smell	yes ☐	no ☐
marijuana smell	yes ☐	no ☐
altered appearance	yes ☐	no ☐

Behavior

slurred speech	yes ☐	no ☐
confused speech	yes ☐	no ☐
staggering	yes ☐	no ☐
poor coordination	yes ☐	no ☐
tremors/shakes	yes ☐	no ☐

Mood

sudden mood changes	yes ☐	no ☐
isolating	yes ☐	no ☐
extreme nervousness	yes ☐	no ☐
belligerent	yes ☐	no ☐
aggressive	yes ☐	no ☐
unusually quiet	yes ☐	no ☐
unusually talkative	yes ☐	no ☐

Vigilance/Performance

confused	yes ☐	no ☐
disoriented	yes ☐	no ☐
drowsiness	yes ☐	no ☐
sleeping	yes ☐	no ☐
hearing things	yes ☐	no ☐
seeing things	yes ☐	no ☐
blackouts	yes ☐	no ☐

Respond to each of the questions below. If you answer yes to any question, explain your response on the back of this form.

Did you see the employee in possession of alcohol or drugs in or on company property or while on company assignment?	Yes	No
Did you see the employee use alcohol or drugs in or on company property or while on company assignment?	Yes	No
Was the employee able to perform assigned duties?	Yes	No
Was the employee involved in an accident?	Yes	No
Did injuries requiring off-site medical treatment, beyond first aide, exist as a result of an accident?	Yes	No
Did an accident cause damage in excess of $1,000	Yes	No

Signature of Supervisor ____________________________ Date ____________

Signature of Supervisor ____________________________ Date ____________

Signature of Supervisor ____________________________ Date ____________