

Employee Counseling Report

Employee Name _____

Description of Incident Requiring Counseling

Related Policies or Accrediting Body Standards Violated (list all that apply)

Required corrective action(s) to be taken on behalf of the employee

Disciplinary Action(s) Taken on behalf of Professional Medical (describe all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Verbal Warning was given to the employee
<input type="checkbox"/> Written Warning Placed into employee's personnel folder
<input type="checkbox"/> Suspension from job without pay for _____ days
<input type="checkbox"/> Corrective Action by the employee to be performed (list above) | <input type="checkbox"/> Reassignment of job duties
<input type="checkbox"/> Additional shifts / duties assigned (or revoked as appropriate)
<input type="checkbox"/> 90 Day probationary period where any additional policy violations will result in termination
<input type="checkbox"/> Dismissal from employment |
|---|--|

Other (explain):

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Witness: _____ Date: _____