COUNSELING FORM

Employee Name **Date**

Department

Position

Date of Incident **Time**

Reason for Counseling:

Details of What Happened:

What is Wrong? How action effects operations?

What must be done to correct problem?

Employee's Comments: _____

_____

_____

Supervisor's Comments: _____

_____

_____

Employee's Signature _____ **Date** _____

Supervisor's Signature _____ **Date** _____

Original to Personnel File Copy Employee