GENERAL STAFF INCIDENT REPORT FORM

DATE OF REPORT

EMPLOYEE NAME	TITLE

MANAGER NAME	TITLE

INCIDENT DETAILS

LOCATION	DATE OF INCIDENT	TIME

DESCRIPTION OF INCIDENT

EMPLOYEE EXPLANATION

WITNESSES

ACTION TO BE TAKEN *select one*

	Verbal Warning		Probation		Dismissal
	Written Warning		Suspension		Other

EXPLANATION OF ACTION TO BE TAKEN

By signing this form, you acknowledge that you have read and understand the information contained herein.

EMPLOYEE SIGNATURE	**DATE**	**EMPLOYEE SIGNATURE**	**DATE**

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