

EMPLOYEE COUNSELING FORM

Employee Name:	Employee Title:
Supervisor or Manager Name:	Supervisor or Manager Title:
Today's Date:	[Incident Date/Performance Period]:
Incident Time (if relevant):	Incident Location (if relevant):

Description of the workplace performance issue or incident (attach additional sheets and backup documentation if necessary):

Names of supervisor(s) and/or manager(s) with knowledge of the workplace performance issue/Witnesses to the incident:

Names of those in attendance at current counseling meeting:

Corrective or disciplinary action to be taken in the short term, effective on [DATE]:

- Oral Warning
 Written Warning
 Suspension Without Pay
 Final Warning
 Discharge
 Other (explain below)

(If Suspension, period begins _____ and ends _____.)

Goals to be achieved/Change in workplace behavior required:

Progress check-in scheduled:

Possible consequences for failure to improve performance or correct behavior:

Prior discussions or warnings on this subject with this employee, whether oral or written (include date):

Employee statement:

I acknowledge that I have read and understand the above information and consequences. I acknowledge that I have received a copy of this form (signature does not indicate agreement with counseling).

Further, I understand that my employment is entered into voluntarily, that I am free to resign at any time, and that [EMPLOYER NAME] may terminate the employment relationship for good cause in the State of Montana.

"Good cause" means reasonable job-related grounds for dismissal based on a failure to satisfactorily perform job duties, disruption of the employer's operation, or other legitimate business reason. MCA 39-2-903

Employee Signature

Date

Supervisor or Manager Signature

Date

Copies to:

- Employee
- Personnel File