**Behavioral Observation Checklist**

Name of observed employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Job Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Check all those indicators or cues observed in the workplace.

**Appearance** **Behavior**

glassy eyes yes  no  slurred speech yes  no 

blank stare yes  no  confused speech yes  no 

bloodshot eyes yes  no  staggering yes  no 

flushed face yes  no  poor coordination yes  no 

alcohol smell yes  no  tremors/shakes yes  no 

marijuana smell yes  no 

altered appearance yes  no 

**Mood** **Vigilance/Performance**

sudden mood changes yes  no  confused yes  no 

isolating yes  no  disoriented yes  no 

extreme nervousness yes  no  drowsiness yes  no 

belligerent yes  no  sleeping yes  no 

aggressive yes  no  hearing things yes  no 

unusually quiet yes  no  seeing things yes  no 

unusually talkative 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? Yes  No 

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 require 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 \_\_\_\_\_\_\_\_\_\_\_\_\_

### Incident/Performance Report

Use this form to record any incidents, workplace performance or workplace 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 Supervisor \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date \_**\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Supervisor \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date \_**\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Supervisor \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date \_**\_\_\_\_\_\_\_\_\_\_\_\_\_**