**Notice of Employee Disciplinary Action**

|  |  |
| --- | --- |
| **Employee Name (To):** | [employee] |
| **Supervisor (From):** | [supervisor] |
| **CC:** | [list] |
| **Date Presented:** | [date] |

**Disciplinary Level:**

[ ] Verbal Correction

[ ] Written Warning

[ ] Notice of Time off Without Pay

[ ] Notice of Permanent Reduction in Pay or Classification

[ ] Notice of Termination

**Subject:**

[Describe the nature of the issue here]

**Prior Notifications:**

[List any prior notifications; verbal or written]

**Incident Description and Supporting Details:** *Include the following information: Time, Place, Date of Occurrence, and Persons Present as well as Organizational Impact.*

**Performance Improvement Plan:**

* Expected Behavior and Conduct Changes:
	+ [list]
* Training or Special Direction to Be Provided:
	+ [list]
* Consequences
	+ [list]

**Interim Performance Evaluation Necessary?** [ ] Yes [ ] No

[List time frame]

**Imposition of Discipline**

[Describe the type of discipline here if there is time off without pay, permeant reduction on pay or classification, or termination.

**Employee Assistance Program:**

The Canton City Health Department’s “Employee Assistance Program” (EAP) provider is *Concern.* This is a service that can help you sort out options, develop a plan of action and take steps toward the positive outcome you desire. *Concern* can be confidentially reached to assist you at (330) 644-7747, with no charge to you initially. The attached booklet describes the EAP’s services. [Using their services is strictly voluntary.] [May be required as part of the PIP]

**Employee Comments:**

[Employee may provide any general comments here]

**Acknowledgment:**

Your signature below confirms that you received a copy of this Notice of Employee Disciplinary Action and it has been discussed with you. This action does not preclude any further action which may be taken against you pursuant to section 207.27 of the Canton City Health Code as a result of this incident.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| Employee Signature |  | Date |  | Supervisor Signature |  | Date |
|  |  |  |  |  |  |  |
|  |  |  |  | Department Head Signature |  | Date |
|  |  |  |  | *(if applicable)* |  |  |
|  |  |  |  | Health Commissioner Signature *(if applicable)* |  | Date |
|  |  |  |  |  |  |  |
| Witness *(if employee refuses to sign)* |  |  |  |  |
|  |  |  |  |  |
| Witness Name |  | Witness Signature |  | Date |

**Attachments:**

* [enter]
* [enter]