



## Fitness for Duty Documentation Form

\_\_\_\_\_  
(EMPLOYEE NAME)

\_\_\_\_\_  
(DATE)

Time of observation: From: \_\_\_\_\_ To: \_\_\_\_\_ Witness: \_\_\_\_\_

### Description of Event:


### Observed Behaviors of Impairment:


### Employee Response to Feedback about Behaviors:


Is the employee willing to submit to a Fitness for Duty Evaluation? Yes  No

Was a drug test completed? Yes  No

Where can the employee be contacted in the next 24 hours? \_\_\_\_\_

### Disposition:

- Sent home with transportation provided
- Transported home with family or friend
- Sent to emergency room or other health care provider

Supervisor Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Give a copy of this form to the employee, HR and fax a copy to Crisis Care International CAP 866.226.3167**

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