

TOWN OF VIENNA
RECORD OF EMPLOYEE COUNSELING

Employee Name:	Position Title:
Dept/Division:	Event Date:
Supervisor Name:	Supervisor Title:

Nature of Event: *Succinctly describe area(s) needing improvement:*

Is this the first occurrence? <input type="checkbox"/> yes <input type="checkbox"/> no If applicable, date(s) of previous occurrences:	Is this the employee's first counseling on this behavior? <input type="checkbox"/> yes <input type="checkbox"/> no If no, date(s) of previous discussions:
--	---

Description of Necessary Improved Behavior(s):

Additional Training Needs Identified? yes no **If yes, list specifics:**

Employee Comments:

Follow-up Date and Time to Discuss Progress:

Employee Signature:	Date:
Supervisor Signature:	Date:
Copy given to Employee by (Signature):	Date: