Date/Time______________
Employee’s Name________________________ Location ____________________
Employee Number ________________________ Supervisor/Phone___________________

Please mark the following using a scale of 1-10. 1 being minimal and 10 being excessive.

ABILITY TO WALK
____ Unable to Walk  _____ Staggering  _____ Swaying
____ Falling  _____ Using object for stability  _____ Stationary

ABILITY TO STAND
____ Rigid  _____ Unable to stand  _____ Swaying
____ Falling

SPEECH
____ Slurred  _____ Incoherent  _____ Shouting
____ Slobbering  _____ Hoarse  _____ Slow

DEMEANOR
____ Irritable  _____ Calm  _____ Excited
____ Indifferent  _____ Cooperative  _____ Hilarious

ACTIONS
____ Resisting  _____ Threatening  _____ Punching
____ Profanity

EYES
____ Bloodshot  _____ Watery  _____ Glassy Eyes

BREATH
____ Alcohol Odor  _____ None

Two supervisors are required to complete separate reports. Please send the originals to Human Resources and a copy of both reports to the Director of the EAP. If additional comments are needed, please use the back of this form.

_______________________
Supervisor