Date/Time_____________

Employee’s Name___________________________ Location __________________________

Employee Number_________________________ Supervisor’s 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

Other remarks:

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                  Date