

MACOMB COUNTY

Human Resources and Labor Relations Department

1 South Main Street, 6th Floor, Mount Clemens, MI 48043 • Phone (586) 469-5280 • Fax (586) 469-6974

CORRECTIVE ACTION FORM

EMPLOYEE NAME: _____

DEPARTMENT/DIVISION: _____

CLASSIFICATION: _____

SUPERVISOR: _____

TYPE OF ISSUE:

- ABSENTEEISM/ATTENDANCE
- JOB PERFORMANCE
- POLICY/PROCEDURE VIOLATION
- OTHER: _____

DATE OF OCCURRENCE: _____

POLICY/PROCEDURE VIOLATED: _____

DESCRIPTION: *Describe the occurrence and all relevant details (attach any supporting documentation)*

PREVIOUS DISCIPLINARY ACTION RECEIVED:

ACTION TAKEN:

- VERBAL WARNING
- WRITTEN WARNING

DEPARTMENT EXPECTATIONS, RECOMMENDATIONS AND TIMELINE:

DEPARTMENT HEAD/SUPERVISOR:

NAME (Printed)

SIGNATURE

DATE

ADDITIONAL COMMENTS:

EMPLOYEE:

By signing below, I acknowledge I have received a copy of this corrective action. I have reviewed the department expectations with my supervisor and I understand failure to correct this behavior and/or further violations may result in additional disciplinary action up to and including discharge.

NAME (Printed)

SIGNATURE

DATE

WITNESS:

NAME (Printed)

SIGNATURE

DATE

CC: Personnel File