St. Clair County Community Mental Health Authority

Incident of Weapons and/or Drugs in the Workplace

ST. CLAIR COUNTY CMHA SITE: _____ ADDRESS: _____

Program: _____

DATE: _____ TIME OF DISCOVERY: _____

TYPE:

☐ Weapons (Describe): _____

☐ Illegal Drugs (Describe): _____

INDIVIDUAL:

☐ SCCCMHA Employee (Name): _____

☐ Individual who receives services from SCCCMHA (Name): _____

☐ Visitor (Name, if known): _____

LAW ENFORCEMENT CONTACTED? ☐ Yes (By Whom?): _____

☐ No

Which Law Enforcement Agency? _____

Name & Title of Law Enforcement Person: _____

Time & Date: _____

ACTION TAKEN: _____

_____

_____

_____

LIST ANY OTHER PERTINENT DETAILS: _____

_____

_____

_____

_____ _____

Supervisor/Designee Signature Date

UPON COMPLETION, FORWARD TO ST. CLAIR COUNTY CMHA ADMINISTRATION FOR FILING

[Associate Director of Administration, Safety Chairman, and Personnel File (if applicable)]

Safety Form: #10-0913
Reviewed Date: 7/1/2023
Policy Ref: #09-003-0025