

Augusta University

Arrest, Charge, Conviction, Plea, or Drug Offense Disclosure Form

Please complete this form in its entirety within 72 hours of the incident. This will assist the Director of Employee Relations in better understanding, addressing, and resolving your report.

Name: _____

Mailing Address: _____

Phone Number: _____ E-mail Address: _____

Job Title: _____ Department: _____

Immediate Supervisor: _____ Phone Number: _____

Please list the following information:

1. the date, time, and place of the incident
2. a factual description of the incident
3. any documentation to support your report
4. outcome (if known)

Your signature certifies the information you provided on this report and any attachments are true and accurate to your knowledge and belief. Additionally, you acknowledge you have received a copy of the following information by checking the boxes below:

Action taken by Augusta University _____

Signature: _____ Date: _____

Director, Employee Relations: _____ Date: _____

Note: Return the completed form to the Director of Employee Relations in Human Resources. Failure to report within 72 hours of the incident will result in immediate discharge.

HR USE ONLY:

Recommendation: