TEMPORARY SCHOOL STAFF SUBSTITUTE TEACHER INCIDENT FORM

TODAYS DATE _____

SUBSTITUTE _____

SCHOOL DISTRICT _____

SCHOOL NAME _____

SUBBING FOR _____

DATE OF INCIDENT (S) _____

PLEASE EXPLAIN IN DETAIL THE INCIDENT (S)

Please also add any additional information on a separate sheet if needed

DO YOU WANT EMPLOYEE TO RETURN?

TO THE SCHOOL **YES** ☐ **NO** ☐

TO THE DISTRICT **YES** ☐ **NO** ☐

PLEASE SEND THIS CONDUCT FORM TO
Dr. Thomas McLennan
E-MAIL: tdmclennan@wayne.edu
OR FAX TO 313-577-9925