

# Supplemental Health Care <sup>SM</sup>

STAFFING SPECIALISTS

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## Employee Evaluation Form

Employee Name/Title:	
Facility:	
Unit Manager:	
Dates of Performance Review:	

<i>Please indicate your responses below:    E=Excellent   S=Satisfactory   U=Unsatisfactory</i>	E	S	U
<b>Attendance:</b>	E	S	U
Reports to work on time for shift report and return from meal break			
<b>Clinical Skills:</b>	E	S	U
Skill level appropriate to clinical assignment			
Adherence to facility policies and procedures			
<b>Performance:</b>	E	S	U
Interpersonal skills with team members			
Cooperation with management team			

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Evaluator's Signature: \_\_\_\_\_ Title: \_\_\_\_\_