

Judy Schmidt, MSN, DHA(c) RN, CCRN
Chief Executive Officer

Terri Ivory-Brown, MSN, RN
RAMP Director

Participant # _____

Employment Evaluation
(To be completed by employer or work site monitor)

Participant Name _____ Month/Year _____

Profession _____ Position _____ Shift _____ Unit _____

Employment Type Full Time Part Time Internship/Volunteer On Call/Per Diem

Employer Information:

Employer _____ Supervisor Name _____

Phone _____ Email _____

Please Rate by Selecting the Appropriate Number and Provide Comments in Space Provided

	Poor					Excellent
	1	2	3	4	5	5
Attendance	1	2	3	4	5	5
Punctuality	1	2	3	4	5	5
Professional in Appearance	1	2	3	4	5	5
Adheres to work place policies/procedures	1	2	3	4	5	5
Exhibits appropriate decision making skills	1	2	3	4	5	5
Work Performance	1	2	3	4	5	5
Behavior when interacting with peers & patients	1	2	3	4	5	5

Comments: _____

Have any worksite drug screens been performed this period? Yes No

Other Questions/Notes/Instructions: _____

Please contact me

Signature

Date