



**PERFORMANCE EVALUATION**

Date: \_\_\_\_\_ Evaluator's Name \_\_\_\_\_ Title \_\_\_\_\_

Facility Name \_\_\_\_\_ Phone \_\_\_\_\_

Facility Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ FAX \_\_\_\_\_

Name of Professional being evaluated: \_\_\_\_\_

What was the Professional's position during his/her employment with you? **MRI CT Ultrasound Nuc Med Mammography**

Professional's dates of employment: From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_. Would you rehire Professional? **YES NO**

**Please rate the quality of work performed by our Professional while at your facility.**

	<b>Excellent</b>	<b>Above Average</b>	<b>Average</b>	<b>Below Average</b>	<b>N/A</b>
Quality of Work	O	O	O	O	O
Productivity/Time Management	O	O	O	O	O
Professionalism	O	O	O	O	O
Ability to Handle Stress	O	O	O	O	O
Flexibility	O	O	O	O	O
Dependability/Follow-Through	O	O	O	O	O
Team Member Skills	O	O	O	O	O
Communication Skills	O	O	O	O	O
Attendance/Punctuality	O	O	O	O	O
Appearance	O	O	O	O	O
Interpersonal Skills/Attitude	O	O	O	O	O
Documentation Skills	O	O	O	O	O
Technical Nursing Competency/Skills	O	O	O	O	O

**COMMENTS:** (Please provide a professional profile of the applicant in three or four sentences.)

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