Employee Shift Evaluation

This Employee Evaluation Report is to be completed by a supervisor and returned to our office by fax (at 888-482-0048) or by mail. We value your responses, as they are a critical component of our quality assurance effort.

FlexRN Employee Name: ______________________

Name of Unit (e.g. M/S, Telemetry, ICU, etc.): ______________________

Client/Facility Name: ______________________

	Excellent	Good	Needs Improvement	Poor	Not Observed
Clinical Skills (Overall)					
Quality of work (Overall)					
Patient Assessment & Observation					
Remains Calm in stressful/emergent situations					
Documentation					
Evaluation of Change in patient Condition					
Patient and Family Education					
Working Knowledge of Advance Directives					
Patient Interaction (age-appropriate communication and care)					
Critical Thinking Skills/Judgement					
Implementation of Physicians Orders					
Time Management					
Initiative and Enthusiasm					
Follows Hospital Policy and Procedures					
Attitude with Co-Workers					
Effective and Timely Communication with Physicians					
Punctuality					
Ability to Adapt to New Workplace					
Compliant with JCAHO Standards					

Additional Comments: ______________________

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Printed Name of Evaluator: ______________________ Date of Evaluation: ____________

Evaluator's Signature: ______________________ Title: ____________

If evaluator is a Charge RN, please have the Unit Manager/Director complete the section below:

Printed Name of Co-Signer: ______________________ Title: ____________

Co-Signer's Signature: ______________________ Date of Signature: ____________

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