

## Clinical Performance Review

---

Please use the following criteria in providing professional feedback for the individual named below. Your time and comments are very much appreciated. We strive to maintain the highest standards of HR practice by diligently screening candidates who meet and/or exceed the requirements mandated by The Joint Commission for Health Care Staffing.

**Please return this form via email to [credentialing@lifelinemedstaffing.com](mailto:credentialing@lifelinemedstaffing.com)**

**NURSE MANAGER / CHARGE NURSE / CLINICAL SUPERVISOR** - Please complete the following:

Evaluator's Name: \_\_\_\_\_ Unit/Setting: \_\_\_\_\_

Title: \_\_\_\_\_ Your Email: \_\_\_\_\_

Name of Facility/Hospital: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Name of Healthcare Professional (HCP) for whom you are providing feedback:** \_\_\_\_\_

Date(s) you supervised this HCP (mm/yyyy – mm/yyyy): \_\_\_\_\_

Was this HCP Agency or Staff? \_\_\_\_\_

Was this HCP Part Time, Full Time, PRN, or Contract? \_\_\_\_\_

<b>Professional Behaviors</b>	<b>Exceeds Standards</b>	<b>Meets Standard</b>	<b>Needs Improvement</b>
Clinical Competence & Judgment			
Flexibility & Adaptability			
Communication Skills			
Time Management Skills			
Utilization of Electronic Medical Records (EMR)			
Attitude & Cooperation			
Attendance & Punctuality			

Is this HCP eligible to return to your facility / hospital? Yes \_\_\_\_\_ No \_\_\_\_\_ Unable to Comment \_\_\_\_\_

Please provide any additional comments about this HCP:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Date: \_\_\_\_\_