PERFORMANCE EVALUATION
CLIENT CLINICAL FEEDBACK

Traveler Name:
Facility Name:

Date:

Reference Name/Title:
Phone Number:

CLINICAL COMPETENCY
Demonstrates competency in caring for patients?
☐ Exceptional  ☐ Exceeded  ☐ Met  ☐ Needs Improvement  ☐ Unsatisfactory

COMMUNICATION
Communicates appropriately with patients and families?
☐ Exceptional  ☐ Exceeded  ☐ Met  ☐ Needs Improvement  ☐ Unsatisfactory

ATTITUDE AND COOPERATION
☐ Exceptional  ☐ Exceeded  ☐ Met  ☐ Needs Improvement  ☐ Unsatisfactory

ATTENDANCE AND PUNCTUALLY
How well did the individual meet your expectation with regard to arriving at his/her job location each day.
☐ Exceptional  ☐ Exceeded  ☐ Met  ☐ Needs Improvement  ☐ Unsatisfactory

Clinical Strengths Comments:

This evaluation was designed to meet Joint Commission on Accreditation of Healthcare Organizations standard. Timely completion is important to us to provide the highest quality professionals.

Evaluation completed by:  Title:
Date of Evaluation:

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