

PROFESSIONAL REFERENCE

Employee's name:

Position Held:

The individual named above has applied for employment with TheraEX Staffing Services. We ask that you provide the information requested below. Your response will be held in the strictest confidence. We have a signed consent from this employee/applicant to release any information pertaining to their employment with you. Thank you for your assistance.

Facility Name:

Street Address:

City:

ST:

Zip:

Manager / Supervisor Name:

Title:

Phone

Unit/Floor/Dept.:

Type of Work Performed: Per Diem Travel Contract Staff

Frequency of Shifts Worked: # Shifts: Per Week Per Month

Employed From: (mm/dd/yy) To:

Is employee eligible for rehire? Yes No If no, please explain:

Specialty:

of unit beds:

Avg. Patient Caseload:

Unit Description:

Charge Experience? Yes No Teaching Hospital? Yes No # Facility Beds:

Using the following key, please rate this employee's skills:

A = Superior; B = Exceeds Standards; C = Meets Standards; D = Does Not Meet Standards

Standard	A	B	C	D	Standard	A	B	C	D
Adaptability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Competency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reliability/Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follows Safety/Emergency Protocols	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teamwork/Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thorough/Accurate Documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Age Specific Competency (please circle the patient population(s) the employee served):

Neonates/newborns	Toddlers	Older children	Young Adults	Middle Adults
Infants	Preschoolers	Adolescents	Older Adults/Geriatrics	

Comments:

Name of Evaluator

Signature *Crystal White*

Title:

Phone: 415-770-8755

Date:

Branch:

Employee taking Reference: Crystal White

(if applicable)