EMPLOYEE

Name: _____

Title: ☐ RN ☐ LPN

ANNUAL EVALUATION

Year: _____

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EMPLOYEE EVALUATION SHEET - PROBATION PERIOD / ANNUAL* (circle)

iCare Home Health & Hospice

Name of Employee: _____

Date of Employment: _____ Position/Title: ☐ RN ☐ LPN

Immediate Supervisor: _____

EVALUATION

ITEM Discussed	Exceptional	Satisfactory	Non-Satisfactory Improvement Needed
Personal appearance/ Code of conduct/ Behavior			
Punctuality/Visits Frequency compliance			
Attitude to work /Attitude to other workers and staff			
Acknowledgment/ Contract-Agreement reviewed			
Attitude-Communication with patients/family			
Responsibility, JOB DESCRIPTION Discussion in details, follow Physician Plan of Care, Updates as needed.			
Confidentiality/Privacy/HIPAA guidelines			
Initiative/Duties/Abilities/QA-QI-PI/Agency Evaluation program participation/learning experience			
Morals/Ethics/Courtesy/Conflict of interest			
Ability to record relevant notes, delivery on time, documentation guidelines compliance			
Ability to communicate in legible, professional manner, participation in Case Conference, follow standards precautions, Infection control compliance.			
Knowledge of professional procedures, equipments-med. device, Participation in continue education, In-services program, Reporting guidelines (Agency, Physician).			
Ability to relate to patient, doctor, community, patient's family and other professionals			
Overall impression regarding quality of care			

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GOALS SETTINGS:_____

_____

_____

Achievement Date: _____

Comments: _____

_____

Employee/Contractor Signature: _____ Date: _____

_____ _____

Signature of Administrator/DON/Evaluator Date

* **Annual Evaluation include:** ☐ Self Evaluation/Input ☐ Joint Visit ☐ Competency ☐ Job Description discussion ☐ GOALS setting
(Managers/Administrators staff: ☐ Leader Evaluation, PAC members ☐ PAC Evaluation)

iCare Home Health & Hospice

EMPLOYEE RESPONSE INPUT (Self Evaluation)

(To improve our services to our patients we need your input and concern, please fil out the following form, and return it to our Agency.)

Employee Name and Title: _____

Date: _____

*** Annual Competency Skill, Evaluation SELF EVALUATION**

As per your annual skill and/or evaluation, we identified:

Area that need Improvement: _____
_____
_____

Please indicate how you will improve your skill and services, planning and goals setting:
_____
_____
_____
_____

Plan of care compliance, career development : _____
_____
_____

Initiative/Duties/Family-Patient rapport _____
_____
_____

*** Annual Joint visit on site, Supervisor/Title: _____ Signature: _____**

As per our joint supervisory visits, we identified the following improvement needed:
_____
_____
_____
_____

Please indicate how you will improve your services, treatment and procedures:
_____
_____
_____
_____

Please indicate any concern and suggestion to improve our services, and our relation with you and with our patients/community:
_____
_____
_____
_____

Employee Signature: _____ Date: _____

Sample
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ACTIVITIES ASSESSMENT CHECKLIST

(R.N. / L.P.N.) iCare Home Health & Hospice

EMPLOYEE'S NAME: _____

INSTRUCTIONS: INSERT DATE AND INITIALS			
PROCEDURE	**ACCEPTABLE DEMONSTRATION**	**DEMONSTRATED KNOWLEDGE VERBALLY**	**NEEDS REVIEW**
1. ADMISSION PROCEDURES/OASIS			
A. MEDICARE-GENERAL B. NON-MEDICARE			
2. HOME HEALTH AIDE EVALUATION			
3. RECERTIFICATION / OASIS			
4. DISCHARGE PROCEDURES / OASIS			
5. REINSTATEMENT HOSPITAL SUSPENSION/HOLD/TRANSFER/OASIS			
6. LEGAL ASPECTS/REPORTING GUIDELINES			
A. PHYSICIAN REPORTING			
B. RECORDING PATIENT RECORD			
7. PSYCHO SOCIAL			
A. ASSESS LEVEL OF UNDERSTANDING OF PT/SO.			
B. TEACHES DISEASE PROCESS			
C. NUTRITIONAL/FLUID TEACHING			
D. S/S REQUIRING MEDICAL INTERVENTION			
8. UNIVERSAL PRECAUTIONS			
A. RED BAG TECHNIQUES HANDLING OF BIOHAZARDOUS WASTE			
B. DISPOSONAL OF NEEDLES			
C. WIPING OFF STETHOSCOPE			
D. HANDLING OF NURSE'S BAG (BAG TECHNIQUE)			
9. EAR, EYES, NOSE & THROAT			
A. TEACH DISEASE PROCESS			
B. TEACHES EAR & EYES DROPS INSTILLATION			
C. THROAT CULTURE			
10. RESPIRATORY SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. RESPIRATORY ASSESSMENT & RATE			
C. DIETARY / FLUID REQUIREMENTS			
D. EXERCISE BREATHING TECHNIQUES			
E. OXYGEN EQUIPMENT & PRECAUTIONS			
F. S/S REQUIRING MEDICAL INTERVENTION			

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EMPLOYEE'S NAME: _____

PROCEDURE	ACCEPTABLE DEMONSTRATION	DEMONSTRATED KNOWLEDGE VERBALLY	NEEDS REVIEW
11. CARDIOVASCULAR SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. FLUID & DIETARY REQUIREMENTS			
C. VITAL SIGN ASSESSMENT: TPR/BP			
D. PERIPHERAL PULSES			
E. SIGNS & SYMPTOMS REQUIRING MEDICAL INTERVENTION			
12. GASTROINTESTINAL SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. FLUID & DIETARY REQUIREMENTS			
C. BOWEL SOUNDS / PALPATION PERCUSSION			
D. NASOGASTRIC & GASTRONOMY TUBES: IRRIGATION & FEEDING			
E. USAGE OF FEEDING MACHINE			
F. MANUAL REMOVAL OF IMPACTION			
G. DIGITAL STIMULATION OF BOWELS			
H. ENEMA PROCEDURES 1. SOAP SUDS 2. FLEETS 3. OIL RETENTION			
I. INSERTION OF ANAL SUPPOSITORIES			
J. OSTOMY PROCEDURES 1. IRRIGATION 2. APPLIANCE CHANGES 3. SKIN PREPARATION/CARE			
K. LAB FOR OCCULT BLOOD & PARASITES IN STOOLS			
L. S/S REQUIRING MEDICAL INTERVENTION			
13. GENITOURINARY SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. FLUID & DIETARY REQUIREMENTS			
C. DAILY CARE OF INDWELLING CATHETER			
D. INSERTION & IRRIGATION OF INDWELLING CATHETER - MALE			
E. INSERTION & IRRIGATION OF INDWELLING CATHETER - MALE			
F. INTERMITTENT CATHETERIZATION MALE			
G. INTERMITTENT CATHETERIZATION FEMALE			
H. APPLICATION & TEACHING OF EXTERNAL CATHETER - MALE			
I. APPLICATION OF DISPOSABLE APPLIANCE FOR SUPRA PUBIC CATHETER CARE			
J. VAGINAL IRRIGATION OR DOUCHE			
K. CLEAN CATCH URINE SPECIMEN			
L. STERILE URINE SPECIMEN FROM FOLEY CATHETER			

Sample
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EMPLOYEE'S NAME: _____

INSTRUCTIONS: INSERT DATE AND INITIALS			
PROCEDURE	**ACCEPTABLE DEMONSTRATION**	**DEMONSTRATED KNOWLEDGE VERBALLY**	**NEEDS REVIEW**
14. ENDOCRINE SYSTEM A. TEACH DISEASE PROCESS & RISK FACTORS (THYROID, PANCREATIC, ADRENAL) 1. S/S OF HYPO 2. S/S OF HYPER			
B. FLUID/DIETARY REQUIREMENTS & MANAGEMENT			
C. INSULIN ADMINISTRATION (SUBCUTANEOUS INJECTION) 1. INSULIN PREPARATION (SINGLE DOSE) 2. INSULIN ADMINISTRATION (SUBCUTANEOUS INJECTION)			
D. BLOOD GLUCOSE TESTING WITH REAGENT STRIPS			
E. BLOOD GLUCOSE TESTING WITH BLOOD GLUCOSE METER (FINGER STICK)			
F. URINE TESTING FOR KETONE			
G. URINE TESTING FOR SUGAR			
H. SKIN/FOOT CARE			
15. NEUROLOGICAL SYSTEM			
A. TEACH DISEASE PROCESS AND RISK FACTORS			
B. LEVEL OF CONSCIOUSNESS			
C. AUDITORY/VISUAL STATUS			
D. S/S REQUIRING MEDICAL INTERVENTION			
E. PUPIL SIZE & REACTION TO LIGHT			

Sample
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EMPLOYEE'S NAME: _____

PROCEDURE	ACCEPTABLE DEMONSTRATION	DEMONSTRATED KNOWLEDGE VERBALLY	NEEDS REVIEW
16. IN TEGUMENTARY SYSTEM			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. SKIN CARE & PREVENTIVE MEASURES			
C. WOUND CARE			
1. DECUBITUS WOUND CARE STAGE I - IV			
D. INCISION			
1. WITH STAPLES			
2. WITHOUT STAPLES			
E. REMOVAL OF SKIN STAPLES OF CLIPS			
F. REMOVAL OF RETENTION SUTURES			
G. WOUND IRRIGATION			
H. HOT/COLD COMPRESSES			
I. STERILE DRESSING TECHNIQUES			
17.ANTEPARTUM / MATERNAL / NEWBORN			
A. TEACH DISEASE PROCESS & RISK FACTORS			
B. PERINEAL CARE, SITZ BATH & DRY HEAT			
C. CHECK FUNGUS LEVEL & KOCHIA			
D. CARE FOR THE NEWBORN INFANT			
E. MOTHER/BABY BONDING			
F. FLUID & DIETARY REQUIREMENTS FOR MOTHER/CHILD			
G. MONITORING OF V.S. (TPR/BP) CHILD ONLY			
H. CAST CARE FOR INFANT/CHILD			
I. GASTROSTOMY/JEJUNOSTOMY TUBE FEEDING			
J. CAPILLARY BLOOD SAMPLES, PKU			
K. TRASH/NASOTRACHEAL SUCTIONING/CARE			
L. INJECTIONS SO/IM			
M. INTRAVENOUS THERAPY			

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EMPLOYEE'S NAME: _____

INSTRUCTIONS: INSERT DATE AND INITIALS			
PROCEDURE	**ACCEPTABLE DEMONSTRATION**	**DEMONSTRATED KNOWLEDGE VERBALLY**	**NEEDS REVIEW**
18. INFUSION THERAPY			
A. TEACH DISEASE PROCESS, PROCEDURES & RISK FACTORS			
B. FLUID & DIETARY REQUIREMENTS			
C. VENIPUNCTURE FOR BLOOD CULTURE, BLOOD CHEMISTRY & MEDICATION LEVEL			
D. INTRAVENOUS SITE CARE & MAINTENANCE			
E. INTRAVENOUS MEDICATION RECONSTITUTION & ADMINISTRATION IN THE HOUSE			
F. OBTAINING BLOOD FOR BLOOD CULTURE/MEDICATION LEVEL VIA CENTRAL LINE			
19. MEDICATIONS MANAGEMENT			
A. INJECTIONS 1. IM 2. SO 3. INTRADERMAL 4. Z-TRACK			
B. ORAL MEDICATIONS			
C. TOPICAL MEDICATIONS			
D. VAGINAL/RECTAL MEDICATIONS & SUPPOSITORIES			
E. AEROSOL TREATMENTS			

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* A minimum of one return demonstration will be performed by a new nursing staff to ensure the safety of the patient and the confidence of the employee. Additional techniques will also be demonstrated as necessary, for new or existing specialty areas of the Agency's service delivery program.

_____ _____
Supervisor Employee's Signature

_____ _____
Date Date

CC: Original to Personnel File/Copy to Supervisor, Employee

BAG TECHNIQUE
COMPETENCY EVALUATION

Employee Name: _____ Title: _____

Items	Yes No N/A	Comments
1. Bag is placed on clean hard surface		
2. Barrier is utilized as appropriate		
3. Bag is placed out of reach of children and animals		
4. Antiseptic no rinse gel or towelettes is available for Handwashing if necessary		
5. Washes hands before entering the bag		
6. Equipment used is cleaned prior to returning to bag if appropriate		
7. Clean and dirty supplies are maintained separately		
8. Supplies are maintained in the bag and checked for expiration on a regular basis		
Additional Comments:		

Sample
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** Never Place the Bag on the Floor or Upholstered Furniture*
** Never Take a Bag into a house with bed bug or insect infestation.*
** Never take a Bag into a house with MRSA or antibiotic resistant organism.*

Signature/Title of Evaluator:_____ Date:_____

iCare Home Health & Hospice

HAND HYGIENE KNOWLEDGE ASSESSMENT QUESTIONNAIRE

(Use this questionnaire to annually survey clinical staff about their knowledge of key elements of hand hygiene)

Staff Name/Title: _____ Evaluator Name/Title: _____ Date: _____

1. In which of the following situations hygiene be performed?
   A. Before having having direct contact with a patient
   B. Before inserting an invasive device (e.g., intravascular catheter, foley catheter
   C. When moving from a contaminated body site to a clean body site during an episode of patient care
   D. After haven direct contact with a patient or with items in the immediate vicinity of the patient or with a patient or with items in the immediate vicinity of the patient
   E. After removing gloves

Mark the number for the answer:
☐ **1.** B and E ☐ **2.** A, B and D ☐ **3.** All of the above

2. If hands are not visible soiled or visible contaminated with blood or other proteinaceous material, which of the following regimens is the most effective for reducing the number of pathogenic bacteria on the hands of personnel?
Mark the letter corresponding to the single best answer:
☐ **A**. Washing hands with plain soap and water
☐ **B**. Washing hands with an antimicrobial soap and water
☐ **C**. Applying 1.5 ml to 3 ml of alcohol-based hand rub to the hands and rubbing hands together until they feel dry

3. How are antibiotic-resistant pathogens most frequently spread from one patient to another in health in health care settings?
Mark the letter corresponding to the single best answer:
☐ **A**. Airborne spread resulting from patients coughing or sneezing
☐ **B**. Patients coming in contact with contaminated equipment
☐ **C**. From one patient to another via the contaminate hands of clinical staff
☐ **D**. Poor environmental maintenance

4. Which of the following infections can be potentially transmitted from patients to clinical staff if appropriate glove use and hand hygiene are not performed?
Mark the letter corresponding to the single best answer:
☐ **A**. Herpes simplex virus infection
☐ **B**. Colonization or infection with methicillin-resistant *Staphylococcus aureus*
☐ **C**. Respiratory syncytial virus infection
☐ **D**. Hepatitis B virus infection
☐ **E**. All of the above

5. *Clostridium difficile* (the cause of antibiotic-associated diarrhea) is readily killed by alcohol-based hand hygiene products
◯ True ◯ False

6. Which of the following pathogens readily survive in the environment of the patient for days to weeks?
   A. E. Coli
   B. *Klebsiella spp*
   C. *Clostridium difficile* (the cause of antibiotic-associated diarrhea)
   D. Methicillin-resistant *Staphyloccus aureus* (MRSA)
   E. Vancomycin-resistant enterococcus (VRE)

Mark the number for the best answer:
☐ **1**. A and D ☐ **2**. A and B ☐ **3**. C, D, E ☐ **4**. All of the above

7. Which of the following statements about alcohol-based hand hygiene products is accurate?
Mark the letter corresponding to the single best answer:
☐ **A**. They dry the skin more than repeated handwashing with soap and water
☐ **B**. They cause more allergy and skin intolerance than chlorhexidine gluconate products
☐ **C**. They cause stinging of the hands in some providers due to pre-existing skin irritation
☐ **D**. They are effective even when the hands are visible soiled
☐ **E**. They kill bacteria less rapidly than chlorhexidine gluconate and other antiseptic containing soaps

Staff signature: _____ Evaluator Signature: _____

Sample
1-855-PNSystem

iCare Home Health & Hospice

HANDWASHING
COMPETENCY EVALUATION

Employee Name: _____ Title: _____

Items	Yes No N/A	Comments
1. Wets hands and wrists completely: points fingers downward		
2. Applies soap over entire hand/wrist area; lathers well		
3. Scrubs hands and wrists well, paying attention to fingernails and between fingers.		
4. Rinses well, keeping fingers pointed Downward		
5. Dries hands and wrists completely Using a paper towel or a clean hand towel		
6. Turns off faucet with the paper towel or cloth towel		
7. If no running water or Handwashing Facilities not available, uses a Packaged Handwashing product or Hand sanitizer		
Additional Comments:		

Sample
1-855-PNSystem

Signature/Title of Evaluator:_____ Date:_____

iCare Home Health & Hospice

Clear Form

Baseline Questionnaire on the _perception_ of hand hygiene and health care-associated infections for _health-care workers_ *(Hand hygiene program field staff survey)*

You are in direct contact with patients on a daily basis and this is a why we are interested in your opinion on health care-associated infections and hand hygiene.

- It should take you no more than 10 minutes to complete to this questions.
- Each question has **one answer only.**
- Please real the questions carefully and then respond spontaneously. Your answers will be kept confidential.

- SHORT GLOSSARY
  Alcohol-Based formulation: an alcohol-containing preparation (liquid, gel or foam) designed for application to the hands to kill germs.
  Handrubbing: treatment of hands with an antiseptic handrub (alcohol-based formulation).
  Handwashing: washing hands with plain or antimicrobial soap and water.

1. Date:_____ Staff Name / Title_____

1. Did you receive formal training in hand hygiene? ◯Yes ◯No

2. Is an alcohol-based formulation available for hand hygiene at your institution? ◯Yes ◯No

3. In general, what is the impact of a health care-associated infection on patient outcome?

   ◯very low ◯low ◯high ◯very high

4. What is the effectiveness of hand hygiene in preventing health care-associated infection?

   ◯very low ◯low ◯high ◯very high

5. Among all patient issues, how important is hand hygiene for the directorate of your institution?

   ◯low priority ◯ moderate priority ◯ high priority ◯ very high priority

6. In your opinion, how effective would the following actions be to increase hand hygiene in our Agency?
   Please tick one "◯" on the scale according to your opinion.

   a. Leaders in our Agency support and openly promote hand hygiene.
   Not effective ◯.....◯.....◯.....◯.....◯.....◯.....◯ Very effective

   b. The Agency makes alcohol-based handrub available to field staff.
   Not effective ◯.....◯.....◯.....◯.....◯.....◯.....◯ Very effective

   c. Hand hygiene poster are displayed at Agency's board as reminders.
   Not effective ◯.....◯.....◯.....◯.....◯.....◯.....◯ Very effective

   d. Each health-care worker is trained in hand hygiene.
   Not effective ◯.....◯.....◯.....◯.....◯.....◯.....◯ Very effective

   e. Clear and simple instructions for hand hygiene are made visible to every health-care worker.
   Not effective ◯.....◯.....◯.....◯.....◯.....◯.....◯ Very effective

   f. Health-care workers regularly receive the results of their hand hygiene performance (during supervision, annual evaluations).
   Not effective ◯.....◯.....◯.....◯.....◯.....◯.....◯ Very effective

   g. You perform hand hygiene perfectly (being a good example for your colleagues).
   Not effective ◯.....◯.....◯.....◯.....◯.....◯.....◯ Very effective

   h. Patients are invited to remind health-care workers to perform hand hygiene.
   Not effective ◯.....◯.....◯.....◯.....◯.....◯.....◯ Very effective

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Staff Name / Title_____

7. What importance does the supervisor attach to the fact that you perform optimal hand hygiene?
   No importance ○.....○.....○.....○.....○.....○ Very high importance

8. What importance do your colleagues attach to the fact that you perform optimal hand hygiene?
   No importance ○.....○.....○.....○.....○.....○ Very high importance

9. What importance do patients attach to the fact that you perform optimal hand hygiene?
   No effort ○.....○.....○.....○.....○.....○ a big effort

10. What is the average percentage of cases where you perform hand hygiene either by handrubbing or handwashing when recommended to do so (between 0 and 100%)?

_____%

Staff signature: _____ Date: _____

Thank you very much for your time!

Your answer will help our Agency to improve our Hand hygiene compliance program.
Your feedback is very important for us.

Sample
1-855-PNSystem

iCare Home Health & Hospice

GLUCOMETER

COMPETENCY EVALUATION

NAME:_____ **Title:** _____

PERFORMANCE CRITERIA	(C)ompetent (I)mprovement needed	COMMENTS
1. Washes hand**;** dons gloves		
2. Turns on glucose meter		
3. Prepares meter by validating the proper calibration with strips to be used; checks expiration dates; records results on Quality Control Log.		
4. Prepares the finger to be lanced & having client wash hands.		
5. Selects finger; cleanses with alcohol pad.		
6. Pricks the client's finger lateral to the fingertip using lancet type device obtaining a large hanging drop of blood.		
7. Applies blood to strip area.		
8. For meters with a "wipe system: - Times the blood contact with the strip - Wipes off blood with a firm stroke using - Cotton ball at appropriate time - Inserts strip into meter for final result/result		
9. For meters with a "no wipe system", allows blood to remain on the strip until results appear on meter.		
10. Covers finger with gauze/tissue until bleeding subsides.		
11. Disposes of lancet in puncture resistant container.		
12. Removes glove; washes hands.		
13. Documents in clinical record as appropriate.		
Additional Comments:		

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Signature/Title of Evaluator:_____ Date:_____

iCare Home Health & Hospice

GLUCOSE METER COMPETENCY

I, _____, have deemed _____
(Name of Person Assessing Competency) (Employee Subcontractor)

Competent in the following tasks:

- ☐ Use of proper infection control techniques puts on gloves prior to using lancing device
- ☐ Calibrates meter according to manufacture's instructions
- ☐ Using lancing device correctly
- ☐ Performs blood glucose testing according to manufacturer's instructions.

Method for Determining Competency: *(check all that apply)*

☐ Return Demonstration ☐ Observation

Was education and/or training provided? ☐ Yes ☐ No

Additional Notes: _____
_____
_____
_____
_____
_____
_____

Sample
1-855-PNSystem

X _____ _____ _____
Signature of Person Demonstrating Competency Title Date

X _____ _____ _____
Signature of Person Assessing Competency Title Date

iCare Home Health & Hospice

YEARLY COMPETENCY GLUCOMETER USE

Score:

Please circle the correct answer.

1. When using a glucometer is not necessary to wash hands before and/or after.

☐ True ☐ False

2. Quality Control Log is used to record the results of the quality control test performed to the glucometer.

True False

3. Lancets are not required to be discarded in the sharp container kept at home.

True False

4. Employees must use gloves while performing the finger stick to patients.

True False

5. When using a lancet device is better to use the fingers lateral to get a large hanging drop of blood.

True False

6. Glucometer calibration and quality control must be performed and recorded daily on nursing notes.

True False

7. It is necessary to clean the finger with alcohol before performing the finger stick.

True False

8. Glucometer must be prepared by validating the proper calibration with the strips to be used and expiration dates must be checked as well.

True False

9. Finger tip should be covered with gauze or tissue until bleeding subsides.

True False

10. After cleaning the finger with alcohol wipes, blowing air is a good practice to dry the finger faster.

True False

Sample
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Employee Name: _____ Title: _____ Date: _____

Evaluator Name and Signature: _____

Sample
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iCare Home Health & Hospice

Leader Evaluation Form

Management Staff Competency Evaluation

Evaluation For: _____ Title _____

Date of Evaluation: ____/____/ _____

Select One Category per question as follows:

1 = Excellent 2 = Good 3 = Average 4 = Poor

A. Customer Service....._____
B. Services & Products Knowledge....._____
C. Communication....._____
D. Effort, Duties, Responsibilities....._____
E. Punctuality....._____
F. Personal Hygiene & Appereance....._____
G. Fairness....._____
H. Diligence....._____
I. Continuing Education & In Service....._____
J. Compliance w/ Policy & Procedures....._____
H. Supervision and Management skills....._____

Specific recommendations for improvements:

_____
_____
_____
_____
_____
_____

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Evaluation Submitted by: _____ Print Name

Sign Name: _____ Date: ___/___/_____

Evaluation Reviewed by Leader: _____ Print Name

Sign Name: _____ Date: ___/___/ _____

iCare Home Health & Hospice

PROFESSIONAL ADVISORY COMMITTEE ANNUAL EVALUATION FORM

Member Name: _____ **Date:** _____

Title: _____

Range: 1 (lees ability) - 5 (great ability)

Topic	Ability (1-5) Qualifications	Accessibility (1-5) Participation	Professionalism (1-5) Knowledge
Advise the Agency on professional issues			
Participation in the evaluation of the Agency program(s), and Annual Evaluation			
Assist the Agency in maintaining liaison with other health care providers.			
Review of Scope of services offered, Admission and D/C polices and procedures			
Review of Policy & Procedures and all others Manuals			
Participation in the Emergency management Program			
Participation in the Clinical Record Review, Services Evaluation, Personnel Qualifications			
Other			

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Comment: _____
_____

Evaluator Name & Title: _____ Signature: _____

Member Signature: _____ Date: _____