

SUPERVISOR/EMPLOYER REPORT

Healthcare

Report Due: Monthly for the first 6 months of full compliance and then quarterly thereafter.

Case #: _____

Name of Probationer: _____

Profession: _____

Employer: _____

Address: _____

Direct Supervisor: _____

Job description/duties: _____

DOPL

ATTN: COMPLIANCE UNIT

PO BOX 146741

SALT LAKE CITY UT 84114-6741

1. Have you read the conditions of probation? Yes No.

If No, please ask the probationer for a copy and read it before submitting this document.

	Excellent	Above Average	Average	Below Average	Unacceptable	Don't Know or	Specific Comments:
2. Interpersonal relationships							
3. Dependability							
4. Attendance							
5. Knowledge/performance of clinical skills							
6. Clinical judgment							
7. Leadership ability							
8. Response to constructive criticism							
	Yes	No	Specific Comments:				
9. Evidence of impairment on the job?							
10. Were random urine samples obtained?			If Yes, what were results?				
11. Access to controlled substances?							
12. Manages controlled substances according to state and federal guidelines?							
13. Access to customer/client funds or property?							
13. Were there any disciplinary problems?							
15. Have there been any reportable complaints from coworkers or patients?							
16. As the employer/supervisor I am ensuring that the limitations and restrictions outlined in the order are being followed.							

ADDITIONAL COMMENTS:

 Supervisor Signature

() -
 Phone Number

/ /
 Signature