CLEAR FORM

Performance Evaluation/Reference

LICENSED HEALTHCARE PROFESSIONAL

Aya Healthcare

Candidate Name: _____

FACILITY CONTACT INFORMATION

Reference Name (Your Name): _____

Title (NM, Charge Nurse, Supervisor, DON, ADON, etc.): _____

Did you supervise the candidate directly? ☐ Yes ☐ No

Telephone (Mobile): _____ Telephone (Work): _____

Email (Work): _____

Facility Name: _____

City & State: _____

CANDIDATE INFORMATION

Profession while working with you (RN, CNA, PT, OT, SLP, etc.): _____

Clinical Specialty: _____

Employment Dates (Approx. Mo/Yr) From: _____ To: _____

Average Nurse/Patient Ratio: _____

Number of Beds in Unit: _____

Number of Beds in Facility: _____

Please let us know if the candidate has the following experience:

Travel Assignment	◯ Yes	◯ No	◯ N/A or Unsure
Charge Nurse	◯ Yes	◯ No	◯ N/A or Unsure
Supervisory	◯ Yes	◯ No	◯ N/A or Unsure
If given the opportunity, would you work with this candidate again?	◯ Yes	◯ No	◯ N/A or Unsure

PERFORMANCE & ATTRIBUTES

3 = Above Standard 2 = Meets Standard 1 = Below Standard

Please make your selections below:

	3	2	1	N/A
Provides competent clinical care	○	○	○	○
Follows facility policies and procedures	○	○	○	○
Flexibility and adaptability	○	○	○	○
Adaptability when communicating with staff	○	○	○	○
Attendance and punctuality	○	○	○	○
Overall professionalism	○	○	○	○
Communicates effectively with patients, family and staff	○	○	○	○
Completes accurate documentation of patient care	○	○	○	○

Please list any strengths you believe would make this candidate successful in another clinical role:

Evaluator Name: _____ **Date:** _____

☐ **By checking this box, I certify all information is true and correct to the best of my knowledge.**

SEND FORM

You may also return the completed form via fax **(858.939.1828)** or email **(references@ayahealthcare.com)**