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 N/A	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

This document may be uploaded to Affinity or submitted by FAX to (801) 530-6404.

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