

# 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		
2. Interpersonal relationships								Specific Comments:	
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

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date

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