

Maryland Professional Rehabilitation Program

VOCATIONAL REPORT

1202 Maryland Ave,
Baltimore, MD 21201-5512
Phone: 410.878.9843
Fax: 410.878.9538

PARTICIPANT: _____

REPORTER: _____

RELATIONSHIP TO THE PARTICIPANT: _____

REPORTING SCHEDULE (CHECK)

March 31 _____
June 30 _____
September 30 _____
December 30 _____

FREQUENCY AND TYPE OF CONTACT (PLEASE CIRCLE BOTH FREQUENCY AND ALL TYPES OF CONTACT)

DAILY WEEKLY MONTHLY PHONE FACE-TO-FACE OTHER: _____

PLEASE COMMENT ON THE FOLLOWING:

POOR EXCELLENT

1. ATTENDANCE & PUNCTUALITY
(COMMENTS AND RECOMMENDATIONS) 1 2 3 4 5

2. WORK PERFORMANCE
(COMMENTS AND RECOMMENDATIONS) 1 2 3 4 5

3. RELATIONSHIP WITH COLLEAGUES
(COMMENTS AND RECOMMENDATIONS) 1 2 3 4 5

4. MANAGING STRESS/ADAPTABILITY
(COMMENTS AND RECOMMENDATIONS) 1 2 3 4 5

5. OVERALL QUALITY OF WORK
(COMMENTS AND RECOMMENDATIONS) 1 2 3 4 5

6. IS THE PARTICIPANT SUBJECT TO ANY DISCIPLINARY ACTIONS OR INVESTIGATION OR CHANGES IN HOSPITAL OR HEALTH CARE FACILITY PRIVILEGES? IF YES, PLEASE EXPLAIN:

7. PLEASE IDENTIFY AND PRESENT CONCERNS OR COMMENTS YOU MAY HAVE REGARDING THIS PARTICIPANT.

SIGNATURE: _____ DATE: _____

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PLEASE RETURN THIS FORM BY FAX OR MAIL USING THE INFORMATION LISTED ABOVE.

PLEASE NOTIFY THE PHYSICIAN REHABILITATION PROGRAM WITHIN 24 HOURS OF ANY OF THE FOLLOWING:

- 1) A positive toxicology screen; 2) Appearing to be imminent danger to self or others; 3) Changes in PRIVILEGES OR employment.