Maryland Professional Rehabilitation Program

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VOCATIONAL REPORT

REPORTING SCHEDULE (CHECK)

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

PARTICIPANT:_____

REPORTER: _____

RELATIONSHIP TO THE PARTICIPANT:_____

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.