

FINAL PROBATIONARY EVALUATION FORM
PROFESSIONAL STAFF ASSOCIATE MEMBERS

Probationary Staff Member:
Department:
Probationary Start Date:
Supervisor:



		Satisfactory	Unsatisfactory
1.0	Clinical competence	<input type="checkbox"/>	<input type="checkbox"/>
2.0	Appropriate use of Hospital resources	<input type="checkbox"/>	<input type="checkbox"/>
3.0	Ability to work and relate to staff and leaders in a collegial and professional manner	<input type="checkbox"/>	<input type="checkbox"/>
4.0	Ability to communicate appropriately with patients and their family	<input type="checkbox"/>	<input type="checkbox"/>
5.0	On-call responsibilities	<input type="checkbox"/>	<input type="checkbox"/>
6.0	Willingness to participate in clinical, teaching and/or research responsibilities and obligations	<input type="checkbox"/>	<input type="checkbox"/>
7.0	Completion of clinical records	<input type="checkbox"/>	<input type="checkbox"/>
8.0	General compliance with Public Hospitals Act, Professional Staff By-Laws and other legislature	<input type="checkbox"/>	<input type="checkbox"/>
9.0	Ethical judgement	<input type="checkbox"/>	<input type="checkbox"/>
10.0	Satisfaction of the College's requirements for continuing medical education	<input type="checkbox"/>	<input type="checkbox"/>
11.0	Please comment on any quality of care issue(s): _____ _____ _____		
12.0	Should any of the assessment points be "unsatisfactory", please expand upon the point from the perspective of identifying issues, examples, and prior discussion with the probationary professional staff member. _____ _____ _____		

Recommendation:

- 1) Continue with Appointment without probation in an Active category
- 2) Continue with Probationary Appointment not to exceed an additional 12 months of practice
- 3) Termination of Appointment

PLEASE PRINT NAME AND SIGN, SUPERVISOR

DATE:

PLEASE PRINT NAME AND SIGN, PROFESSIONAL STAFF MEMBER

DATE:

PLEASE PRINT NAME AND SIGN, CHIEF OF DEPARTMENT

DATE: