REHAB ALTERNATIVES

CLINICIAN REFERENCE

CLINICIAN NAME _____ DATE _____

DISCIPLINE _____ DEPARTMENT/UNIT _____

PLEASE SELECT: ☐ SUPERVISOR ☐ MANAGER ☐ INSTRUCTOR ☐ OTHER _____

CLINICIAN ASSIGNMENT TYPE: ☐ FULL-TIME ☐ PART-TIME ☐ CASE WORK ☐ OTHER _____

DATES / DURATION OF ASSIGNMENT : _____

PLEASE CHECK THE APPROPRIATE BOX BASED UPON THE CLINICIAN'S DEMONSTRATED ABILITIES AND BEHAVIOR.

EVALUATION CRITERIA	SUPERIOR	ABOVE AVERAGE	ACCEPTABLE	INADEQUATE
COMPETENCY AND KNOWLEDGE BASE				
PERFORMANCE OF PATIENT CARE				
PROFESSIONALISM AND ATTITUDE				
DOCUMENTATION SKILLS				
COMMUNICATION SKILLS				
ATTENDANCE				
PUNCTUALITY				
MANAGEMENT/LEADERSHIP SKILLS (IF APPLICABLE)				

WOULD YOU RECOMMEND THIS CLINICIAN? ☐ YES ☐ NO

ADDITIONAL COMMENTS: _____

_____

REFERENCE BY:

NAME _____

TITLE _____

AUTHORIZED BY: FOR INTERNAL USE ONLY

NAME _____

TITLE _____

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