



Contractor Performance Feedback

To be completed by Office Manager or Doctor

Employee Name: _____ Assignment Date: _____

Doctor: _____ Location: _____

In the space provided, please comment on work performance.

	Exceeds	Meets	Needs Improvement
Interactive with staff:	_____	_____	_____
Technical skills:	_____	_____	_____
Communication skills:	_____	_____	_____
Willingness/Ability to follow through:	_____	_____	_____
Patient interaction:	_____	_____	_____
Infection control:	_____	_____	_____

Did he/she arrive on time and ready to work? Yes _____ No _____

Would you enjoy having him/her in your office again? Yes _____ No _____

If no, please explain

Comments: _____

Employer Signature: _____ Date: _____