Dental Ink
HEALTHCARE STAFFING AGENCY

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:_____

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Employer Signature: _____ Date:_____

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