



## Professional Reference Request

\_\_\_\_\_ has applied for a position with Signature Healthcare and has given  
*Applicant Name*

us your name as a professional reference. It would be appreciated if you would complete the applicants past performance evaluation. Any additional comments are welcomed as you feel they might assist us in making our hiring decision.

***(To be completed by the applicant):***

Name and Title of person to complete this evaluation: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip Code: \_\_\_\_\_

Dates employed: From: \_\_\_\_\_ To: \_\_\_\_\_

Applicant's Title: \_\_\_\_\_ Unit Name: \_\_\_\_\_

Unit Specialty: \_\_\_\_\_ # Unit Beds: \_\_\_\_\_

***(To be completed by the evaluator):***

<b>Clinical Performances:</b>	<b>Exceeds Expectations</b>	<b>Meets Expectations</b>	<b>Does Not Meet Expectations</b>
Demonstrates competency for assigned patient population including adaptations for age specific care and cultural competency.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assesses patients in a timely manner according to patient need.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performs medical interventions in a timely, accurate and safe manner.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicates appropriately with patients, families, visitors and all members of the disciplinary team.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reports to work punctually and as scheduled. Gives appropriate notification if unable to work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Maintains patient confidentiality at all times.....

Works collaboratively with all members of the  
disciplinary team.....

Documents patient cares properly.....

**Evaluator**

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Would this person be eligible for rehire? \_\_\_\_\_ Yes \_\_\_\_\_ No

Signature of person completing evaluation \_\_\_\_\_ Date: \_\_\_\_\_

***(Applicant Authorization):***

I authorize, \_\_\_\_\_ to release the above information about me to Signature Healthcare for the purpose of reference/past clinical performance check.

\_\_\_\_\_  
*Applicant Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Applicant Name*



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