BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

RESPIRATORY CARE BOARD OF CALIFORNIA

3750 Rosin Court, Suite 100, Sacramento, CA 95834

T: (916) 999-2190 | Toll-Free: (866) 375-0386 | F: (916) 263-7311

E: rcbinfo@dca.ca.gov | www.rcb.ca.gov

SUPERVISOR QUARTERLY REPORT OF PERFORMANCE

NAME OF PROBATIONER:		PROBATIONER'S TITLE:	
EMPLOYER NAME:			
EMPLOYER ADDRESS:			
	CITY:	STATE:	ZIP:
TELEPHONE NUMBER:	MAIN:	DEPT.:	
EMAIL:			

Report Period:	Due to the Board Between:
☐ January 1st – March 31st	☐ April 1st – April 7th
☐ April 1st – June 30th	☐ July 1st – July 7th
☐ July 1st – September 30th	☐ October 1st – October 7th
☐ October 1st – December 31st	☐ January 1st – January 7th
☐ Other: ____________________ to ____________________	

THE FOLLOWING QUESTIONS REFER TO THE TIME PERIOD SINCE YOU LAST COMPLETED A QUARTERLY REPORT OF COMPLIANCE

1. As the employer, did the probationer provide you with a copy of the Decision and Order in this case?	Yes ___	No___
2. As the employer, did the probationer provide you with a copy of the Accusation or Statement of Issues in this case?	Yes ___	No___
3. Has the probationer had any substandard ratings, adverse reports, actions, or disciplinary actions taken, including, but not limited to, counseling letters, informal reprimands, formal reprimands, termination, suspension, or other disciplinary actions? *If yes, explain in detail below or on a separate sheet of paper.	Yes ___	No___

4. Please circle below each day worked for the past three months of employment:

MONTH ____________________

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

MONTH ____________________

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

MONTH ____________________

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

5. Please provide the number of hours this employee worked during the reporting period.	No. Hours ___________ Per: (circle one) Week Bi-Week Bi-Monthly Month
6. What shifts is the probationer most often scheduled to work?	Circle one: AM or PM Start Time: _________ End Time: ________

7. If direct supervision is required in the probationer's probation terms, has the employee had any changes in the assigned supervisor(s)? If yes, please provide the name of the supervisor(s): ____	Yes ___	No___

8. Has the probationer performed in a management or supervisory capacity during this reporting period?	Yes ___	No___
9. Has the probationer performed in a lead capacity during this reporting period?	Yes ___	No___
10. Has the probationer worked in home care during this reporting period?	Yes ___	No___
11. Has the probationer provided clinical or classroom instruction or supervision to respiratory care students or applicants?	Yes ___	No___
12. Has the probationer worked as part of a transport team?	Yes ___	No___
13. To your knowledge, has the probationer exhibited any symptoms of drugs or alcohol use? *If yes, please explain in detail below.	Yes ___	No___
14. To your knowledge, has the probationer been involved in any unlawful act? *If yes, please explain in detail below.	Yes ___	No___

If you answered yes to questions 3, 13 or 14, please explain in detail below. This area may also be used for any additional comments regarding the probationer. Please attach another sheet if additional space is needed. You may also provide any performance evaluations, corrective actions, or commendations given during this period.

DETAILS: ____

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ASSESSMENT OF WORK PERFORMANCE

	Does Not Meet Standard	Meets Standard	Exceeds Standard
Performs all respiratory care procedures in a professional, safe, and competent manner	☐	☐	☐
Accurate patient record keeping	☐	☐	☐
Reports problems to supervisor	☐	☐	☐
Maintains professional proficiency	☐	☐	☐
Attitude/Cooperation	☐	☐	☐
Attendance/Punctuality	☐	☐	☐
Interpersonal/Staff Relations	☐	☐	☐

REGISTRIES ONLY – Please list all hospitals or places referred to which the probationer was assigned since the last time you completed a quarterly report of performance. Please include the following information on an attached piece of paper: a) hospital/facility name, b) contact person, and c) telephone number.

PRINT NAME ______________________ TITLE ______________

SIGNATURE ______________________ DATE ______________

THIS FORM MUST BE SUBMITTED DIRECTLY TO THE BOARD BY THE EMPLOYER