



Respiratory Care Board of California

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SUPERVISOR QUARTERLY REPORT OF PERFORMANCE

Name of Probationer: _____

Probationer's Position/Title: _____

Employer Name: _____

Employer Address: _____

Employer Telephone: _____

Check Appropriate Box for Reporting Period Covered

<u>Report Period</u>	<u>Report Due to the Board between</u>
<input type="checkbox"/> January 1 st - March 31 st	April 1 st - April 7 th
<input type="checkbox"/> April 1 st - June 30 th	July 1 st - July 7 th
<input type="checkbox"/> July 1 st - September 30 th	October 1 st - October 7 th
<input type="checkbox"/> October 1 st - December 31 st	January 1 st - January 7 th
<input type="checkbox"/> Other: _____ to _____	

1) As the employer, did the probationer provide you with a copy of the Decision and Order of probation 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 or suspension, or other disciplinary actions? YES [] NO []

IF YOU ANSWERED YES, please explain in detail below or on a separate sheet of paper

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*

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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 this reporting period: **No. Hours:** _____
Per: (Circle One) Week 2 Weeks Bi-Monthly Month

6) What shift is the employee most often scheduled to work [i.e. 6PM - 6AM]? Circle one: AM or PM Start Time: _____ End Time: _____

- 7) If "Direct Supervision" is required in the RCP's probationary terms, has the employee had any changes in the assigned supervisors?
If yes, please provide the name of new supervisor _____ YES [] NO []
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- 8) Has this employee performed in a management or supervisory capacity during this reporting period? YES [] NO []
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- 9) Has this employee performed in a lead capacity during this reporting period? YES [] NO []
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- 10) Has this employee worked in home care during this reporting period? YES [] NO []
-
- 11) To your knowledge, has the employee exhibited any symptoms of drug or alcohol use?
IF YES, please explain in detail below YES [] NO []
-
- 12) To your knowledge, has the employee been involved in any unlawful act?
IF YES, please explain in detail below YES [] NO []
-

ASSESSMENT OF WORK PERFORMANCE

	Does Not Meet Std.	Meets Standard	Exceeds Standard
Performs all respiratory care procedures in a professional, safe and competent manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accurate patient record keeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reports problems to supervisor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintains professional proficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attitude/Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance/Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal/Staff Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the space below to explain in detail any sub-standard ratings and/or provide your explanation on the questions above to which you answered "Yes." This area may also be used for any additional comments regarding the employee. Attach another sheet if additional space is needed and a any performance evaluations, corrective actions, or commendations given during this period.

REGISTRIES ONLY - Please list ALL hospitals or places referred to which the employee was assigned since the last time you completed a quarterly report of performance. Please include the following information on an attached piece of paper: 1) Hospital/ Facility, 2) Contact Person, and 3) Telephone Number.

Supervisor's Name (Please Print)

Supervisor's Title (Please Print)

Supervisor's Signature

Date