



Medical Professionals Health Program

Worksite/Peer Monitor Report Form

(To be completed by employer or worksite/peer monitor)

MPHP participant name: _____

Report date: _____ **Monthly report / Quarterly report** (per MPHP agreement and/or CA)

Dates of observation? _____

	Excellent	Satisfactory	Fair	Needs improvement	N/A
Arrives to work on time consistently, and works entire shift as scheduled					
No observed accidents or errors					
Uses good judgement					
Shows clinical competence					
Behaves in a professional manner					
Has positive interactions with other staff and supervisors					
Has positive interactions with patients					
Works well as a member of the team					
Functions independently as appropriate					
Uses logical steps when planning care					
No known patient complaints					

I have concerns about their behavior, state of mind, and/or well-being. Yes No

I have concerns about their quality of work or absences. Yes No

Would you like the MPHP to call you for this reporting period regarding this participant?
 Yes No

Please use this space for any comments that you may have:

Employer/Monitor's signature

Date

Employer/Monitor's name (**PRINT or TYPE**)

Relationship to participant

Employer/Monitor's work address

Telephone number

PO Box 69 ♦ Manchester, ME 04351 ♦ (207) 623-9266 ♦ Fax: (207) 430-8386