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SUPPLEMENTAL STAFFING RESOURCE
 Federal Tax ID #: **68-0566960**

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Health Care Staffing
 Services Certification by
 The Joint Commission

PERFORMANCE EVALUATION / PROFESSIONAL REFERENCE CHECK

(Please have your reference fill this form out completely before returning to Critical Options.)

Employers Please Note: The individual whose name appears below has applied for a nursing position with Critical Options and has given us your name as a professional reference. We would appreciate it if you would evaluate the applicant's past performance and make any additional comments you feel might assist us in making our decision in hiring this nurse. Your comments will be kept in strict confidence.

I authorize _____, at (_____) _____ - _____
 Name of Nurse Manager, Nurse Director, or Medical Director (past or present employers) Phone Number

from _____ located at _____
 Facility Name Facility Address: City State Zip

to release information about my job performance while in their employment, whether permanent or temporary, for the purpose of supplying a reference check. I hereby release all such employers and their representatives from all liabilities for issuing this information to Critical Options, Inc. I also authorize Critical Options, Inc. to disclose to the client, facilities in which I have expressed an employment interest.

 Name of Applicant (please print) Signature of Applicant Social Security Number Date

Nurse was employed: From _____ To _____ Nurse's Title: _____

Area(s)/Unit(s) Worked: _____ Type/Size of Unit(s): _____

	Exceeds Expectations	Meets Most Expectations	Meets Some Expectations	Does Not Meet Expectations
Ability to Work Well with Others	_____	_____	_____	_____
Accurate and thorough documentation	_____	_____	_____	_____
Appearance	_____	_____	_____	_____
Attendance / Punctuality	_____	_____	_____	_____
Clinical Skills	_____	_____	_____	_____
Communication Skills	_____	_____	_____	_____
Customer Service Skills	_____	_____	_____	_____
Emotional Stability	_____	_____	_____	_____
Enthusiasm Toward Job	_____	_____	_____	_____
Flexibility	_____	_____	_____	_____
Leadership Ability	_____	_____	_____	_____
Problem Solving Skills	_____	_____	_____	_____
Professionalism	_____	_____	_____	_____

Would you hire this nurse again? Yes No Conditional

Optional: Reason this nurse left your facility: Terminated Lay-off Resigned Temporary Still Employed

Additional Comments (please continue on back if more room is needed) _____

Signature: _____ Date: _____

INTERNAL USE ONLY		
Person verifying reference: _____		
Verbal <input type="checkbox"/>	Written <input type="checkbox"/>	Date: _____