Elohim Medical Staffing Agency, Inc.

FIRST SHIFT CHECKLIST/ TIME SHEET

Competency assessment/ Performance Evaluation

FAX TIME SLIP TO: 515-257- 7260
EMAIL TO: timesheet@elohimhcs.com
Weekly pay (hours worked from **Monday** through **Sunday**)
Time slips are due **Monday by 8.00AM** for the previous week worked.

Employee Name:

Facility Name:

Orientation Date: / / Start time: **End Time:** **Total Time:**

Orientation: complete prior to providing care, treatment, or services. Please ensure all areas have been addressed and are completed.

Facility staff please initial each topic completed or place NA if not applicable.

___Tour of unit(s) working
___Orientation of policies/procedures.
___Review Emergency Protocol
___Review of physical layout of facility
___Infection control
___Documentation (Computer, Charting, Paperwork, Restraints)
___Medication Administration (Orientation, Documentation,

Competency Assessment/Performance Evaluation: To assist with our evaluation process, we would appreciate your assessment of the performance of this person. Please check the appropriate boxes and make additional comments you feel may be of assistance in our ongoing quality assurance program. Thank you.

	Exceeds	Meets	Don't Meet	N/A
Prioritizes assignments based on patient condition	( )	( )	( )	( )
Plans care in collaboration with healthcare team	( )	( )	( )	( )
Conducts assessments per standard of care	( )	( )	( )	( )
Carries out physician orders accurately and timely	( )	( )	( )	( )
Documents per policy completely and accurately	( )	( )	( )	( )
Performs nursing interventions per standard of care	( )	( )	( )	( )
Maintains confidentiality	( )	( )	( )	( )

7618 Hickman Rd Windsor Heights, IA 50324

www.elohimhcs.com Email: info@elohimhcs.com Phone: (515) 999-7701 or (515) 599-3399

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Protocol). ___Review Emergency Evaluation Procedures (Fire, Tornado, etc.) ___Equipment to be used by HCP (Glucometer Pump, etc.) ___Other_____ _____.	Works within scope of practice Performs skills and duties assigned competently Additional comments & concerns:	( ) ( )	( ) ( )	( ) ( )	( ) ( )

Facility Representative name: _____ Title: Signature:

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