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| **ASSESSMENT FORM** | | | | | | |
|  | | | | | | |
| **Candidate Name:** |  | | | | | |
| **Organisation:** |  | | **Ward/Department:** | |  | |
| **Employment Dates- From:** |  | | **Dates- To:** | |  | |
| **Please tick as appropriate** | **Unable To Comment** | **Poor** | **Satisfactory** | **Good** | **Very Good** | **Excellent** |
| **Clinical skills demonstrated in line with the requirements of the position.** |  |  |  |  |  |  |
| **Relationships with patients, other healthcare workers and members of the public.** |  |  |  |  |  |  |
| **Time keeping and management of work load.** |  |  |  |  |  |  |
| **Patient records and other records management.** |  |  |  |  |  |  |
| **Reliability.** |  |  |  |  |  |  |
| **Communication skills.** |  |  |  |  |  |  |
| **Supervision skills.** |  |  |  |  |  |  |

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| **Assessor’s Name:** |  |  | In order to Validate Assessment Form, Please Provide Official Stamp, Signed Compliment Slip or Official Letter Head Paper. |
| **Assessor’s Signature:** |  |
| **Position:** |  |
| **Date:** |  |