



To be completed by Office Manager or Doctor:

## Temporary Performance Feedback

Temporary Employee Name: \_\_\_\_\_ Assignment Date: \_\_\_\_\_

Doctor: \_\_\_\_\_ Location: \_\_\_\_\_

In the space provided, please comment on work performance.

	Exceeds	Meets	Needs Improvement
Interactive with staff	_____	_____	_____
Technical skills	_____	_____	_____
Communication skills	_____	_____	_____
Willingness/Ability to follow through	_____	_____	_____
Patient interaction	_____	_____	_____
Infection control	_____	_____	_____

Did she/he arrive on time and ready to work?      Yes      No

Would you enjoy having her/him in your office again?  
(if no, please explain)      Yes      No

Additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctors/Manager's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax or send to Dental Medical Staffing, Inc. Thank you for your comments.