TEMPORARY FILL-INS
DENTAL STAFFING AT ITS BEST

Performance Review

Employee Name: _____ Date: _____
Doctor/Location Name: _____ Assignment Date: _____

In the space provided below, please comment on work performance.

	NEEDS IMPROVEMENT	MEET	EXCEEDS
Team Player:	○	◉	○
Technical Skills	◉	○	○
Communication Skills	○	○	◉
Appearance	○	○	◉
Patient Interaction	○	○	◉
On Time/Prompt	○	○	◉
Self-Motivated/ Efficient	○	○	◉

Would you enjoy having him/her in your office again? ☐ Yes ☐ No

Additional Comments: _____
_____

Doctors Signature: _____