BRIGHAM AND WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115

COST CENTER: _____ – _____ – _____

TO: _____ DEPARTMENT: _____

FROM: Department of Human Resources

RE: Three Month Evaluation of: _____ _____
Employee Employee Number

The three (3) month initial review period for the above-named employee will end on _____
This form must be completed, discussed with the employee and returned to the Department of Human Resources prior to the completion of his/her three months of employment.

CHECK (✓)THE MOST APPROPRIATE BOX	EXCELLENT	COMMENDABLE	COMPLETELY MEETS JOB STANDARDS	MINIMALLY ACCEPTABLE	UNACCEPTABLE
1. QUALITY OF WORK: Is work thorough, and accurate for length of service?	☐	☐	☐	☐	☐
2. QUANTITY AND TIMELINESS OF WORK: Is an acceptable amount of work accomplished for length of service?	☐	☐	☐	☐	☐
3. FOLLOWS INSTRUCTIONS AND REGULATIONS?	☐	☐	☐	☐	☐
4. APPLICATION TO THE JOB: Steady worker - interested, willing and dependable? Completes assignments?	☐	☐	☐	☐	☐
5. COOPERATION: Works appropriately with others?	☐	☐	☐	☐	☐
6. SAFETY: A safe worker? Follows safe practices in working? Attended Infection Control? ____Yes ____No Inservice Date: _____	☐	☐	☐	☐	☐

Specify areas where performance has been excellent: _____
(Use back of this sheet, if necessary)

Specify areas where performance needs improvement: _____
(Use back of this sheet, if necessary)

Number of days absent: _____ Number of late arrivals: _____ Recommend for continuing employment? YES _____ NO _____

If you are terminating this employee, please explain (Use back of this sheet, if necessary and attach termination notice) _____

Employee's Comments (Use back of this sheet, if necessary)

_____ _____
Evaluating Supervisor/Department Head Date

_____ _____
Employee's Signature Date

50600543 8/93

White: Human Resources **Yellow: Employee** **Pink: Department**