

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? Yes No

Additional comments:

Doctors/Manager's Signature: _____ Date: _____

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