The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
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Pharmacy Substance Use Disorder (PSUD) Program

JOB PERFORMANCE PROGRESS REPORT

Please complete the following information on a regular basis, as stipulated in the PSUD Participant's Treatment Contract, and forward directly to the PSUD participant.

This form must be completed in entirety by the Supervisor.

Licensee/Employee: _____

Original Date of Employment: _____ Date of Report: _____

Time Period Covered by this Evaluation: From _____ to _____

1. FIELD/TYPE of profession: (Check appropriate box)

□ Pharmacy	□ Genetic Counseling
□ Dentistry	□ Nursing Home Administration
□ Physicians Asst.	□ Respiratory Therapy
□ Perfusionists	□ Other (describe) :

2. POSITION as professional being evaluated: _____

3. SCHEDULE: (Check all that may apply)

□ Part-time	□ Days
□ Full-time	□ Evenings
□ Weekends	□ Varied
□ 12-Hour Shifts	□ Other (describe) :

4. ATTENDANCE:

Number of days absent in the past three (3) months: _____

□ A pattern of absenteeism/tardiness does exist. Describe:

5. QUALITY OF WORK

□ Exceptional □ Above Average □ Satisfactory □ Unsatisfactory

Comment:

6. Follows POLICIES AND PROCEDURES: (Please comment)

   □ Exceptional Comment:
   □ Above Average
   □ Satisfactory
   □ Unsatisfactory

7. If the licensee administers/prescribes MEDICATIONS or has access to medications, have there been any errors or discrepancies: (Explain)

   □ Errors Comment:
   □ Discrepancies

8. INTERPERSONAL RELATIONSHIPS with co-workers/peers:

   □ Very Good Comment:
   □ Satisfactory
   □ Unsatisfactory

9. JUDGMENT AND COGNITIVE ABILITIES:

   □ Very Good Comment:
   □ Satisfactory
   □ Unsatisfactory

10. PRACTICE RESTRICTIONS: (Check all which apply)

    □ Practice in a structured, supervised setting
    □ No passage of, or access to, controlled substances, Classes II-V
    □ Not to work in high stress/high access area
    □ Work up to 40 hours: □ day, □ evening, □ night shifts
    □ No floating
    □ May work up to _____ hours of overtime
    □ Other:

11. In the past 3 months, has the Licensee been counseled, given a warning or disciplined in the work setting?

    □ Yes □ No Comment: _____

12. To the best of your knowledge, do you believe that the licensee is MAINTAINING ABSTINENCE from alcohol, drugs and/or chemicals of abuse:

    □ Yes □ No Comment: _____

13. Use this space for further comments, questions or concerns.

_____ _____
Supervisor Name/Title Agency

_____ _____
Supervisor's Address Telephone