Professionals Resource Network

Workplace Monitor Update Form

Please fax (904-261-3996) or email to admin@flprn.org quarterly

Practitioner: ______________________________ **Date:** ______________

Location of Practice: ____

Please evaluate each area of performance by circling the appropriate answer (Yes or No)

1. Have there been any concerns in the workplace expressed by patients, staff, or others?	Yes	No
2. Has any patient or the practitioner reported patient interactions outside of the office?	Yes	No
3. Displays ethical, respectful, and professional behavior with patients, family members, and staff.	Yes	No
4. Sees patients during normal business hours.	Yes	No
5. Limits self-disclosure at work.	Yes	No
6. Do you have any direct knowledge of workplace impairment since your last update?	Yes	No
7. Do you have any concerns about the practitioner's ability to practice safely?	Yes	No
8. Would you like the Case Manager to contact you?	Yes	No

Please explain any yes answers to questions 1, 2, 6, 7, or 8. ______________________________

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Please explain any no answers to questions 3, 4, or 5. ______________________________

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Workplace Monitor's Name **Workplace Monitor's License Number**

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Workplace Monitor's Telephone Number **Workplace Monitor's Email Address**