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. Displays ethical, respectful, and professional behavior with patients, family members, and staff.	**Yes**	**No**
3. Sees patients during normal business hours.	**Yes**	**No**
4. Limits self-disclosure at work.	**Yes**	**No**
5. Do you have any direct knowledge of workplace impairment since your last update?	**Yes**	**No**
6. Do you have any concerns about the practitioner's ability to practice safely?	**Yes**	**No**
7. Would you like the Case Manager to contact you?	**Yes**	**No**

Please explain any yes answers to questions 1, 5, 6, or 7. _____

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Please explain any no answers to questions 2, 3, 4. _____

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

_____ _____

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