Physicians' HEALTH Program

The Foundation of the Pennsylvania Medical Society

CONFIDENTIAL

Workplace Monitor Report

Participant's Name:____

Time period covered in this report:_____________________________________

Information on this form is strictly confidential.
Please be cognizant of this while it is in your possession.

Frequency of Contact:____

Relationship to Participant:

- ❑ Partner ❑ Peer ❑ Other_______________

Promptness and Reliability:

- ❑ Good ❑ Fair ❑ Poor

Overall Attitude:

- ❑ Good ❑ Fair ❑ Poor

Ability to Work with Peers and Other Staff:

- ❑ Good ❑ Fair ❑ Poor

Any concerns about patient or staff interactions since last report?

- ❑ Yes ❑ No

Please specify if yes:____

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Please complete both sides.

Please check any areas of concern:

Appearance:

- ❑ Disheveled
- ❑ Red or Yellow Eyes
- ❑ Pupils Constricted/Dilated
- ❑ Ongoing Physical Characteristic (glassy eyes, tremors, runny nose) ____________
- ❑ Poor Personal Hygiene (body odor, appropriate dress, etc.) ___________________
- ❑ Other change in appearance ____

Behaviors:

- ❑ Mood Swings
- ❑ Negative Attitude
- ❑ Argumentative
- ❑ Inappropriate Anger
- ❑ Overreaction to Criticism
- ❑ Personality Change
- ❑ Odd Hours for Rounds
- ❑ Avoids Meetings/Isolating
- ❑ Avoids Eye Contact
- ❑ Shifts Workload
- ❑ Other changes in behavior ____

Complaints:

- ❑ Staff
- ❑ Patient

Comments: ____

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Print Name of Monitor: ____

Address: ____

Email: ____

Telephone number: ____

Signature: __________________________________ Date: ________________________

Physicians' Health Program
777 East Park Drive, P.O. Box 8820
Harrisburg, PA 17105-8820
(866) 747-2255 or (717) 558-7819
FAX (855) 933-2605