

# ASSOCIATE PERFORMANCE EVALUATION

DATE: \_\_\_\_\_ ASSOCIATE: \_\_\_\_\_

DATE OF HIRE: \_\_\_\_\_ EVALUATOR(s): \_\_\_\_\_

**PROFESSIONAL EVALUATION** – Please rank on a scale of 1 to 5, with 5 as the highest. If you have not observed performance mark N/A. Use separate sheet as appropriate for remarks.

1. PERFORMANCE	1	2	3	4	5	N/A	REMARKS
<b>GENERAL RADIOLOGY</b>							
<b>CT</b>							
<b>MRI</b>							
<b>MAMMOGRAPHY</b>							
<b>NUCLEAR MEDICINE</b>							
<b>ULTRASOUND</b>							
<b>INTERVENTIONAL PROC</b>							

2. WORK HABITS	1	2	3	4	5	N/A	REMARKS
Arrives on time							
Works full shift and is available to staff							
Provides Timely Reports							
Volume of Work Performed							

<b>2. WORK HABITS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>N/A</b>	<b>REMARKS</b>
Responsive to Peers, Staff and Patients							
Communication – answers pages/phone							
Performance of Administrative Duties							
Corporate Compliance Training and Awareness							
HIPAA Compliance Training and Awareness							
Seeks out guidance as necessary							

<b>3. COMPATIBILITY</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>N/A</b>	<b>REMARKS</b>
Interacts well with Peers							
Interaction with Ancillary Staff							
Interaction with Administration							
Interaction with Patients							

**4. Associate Strengths and Potential**

**5 Opportunities for Improvement/ Required Improvements**

**6. Are there any issues which may potentially affect shareholder election ( ) YES ( ) NO**  
If YES, Explain

**7. Goals and Objectives Next 12 Months (Attach Action Plan)**

**8. Comments**

\_\_\_\_\_  
Evaluator Name: (Print) \_\_\_\_\_

\_\_\_\_\_  
Evaluator Signature

\_\_\_\_\_  
Associate Signature

\_\_\_\_\_  
Date: \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_