Health Professionals' Services Program Workplace Monitor Safe Practice Report

HPSP requires the following safe practice report form be completed by the workplace monitor and that the form be sent directly to Uprise Health HPSP. **This form must be submitted on a monthly basis in order for the Licensee to be in compliance with his/her monitoring agreement. Please either mail or fax this form to Uprise Health by the close of business on the 5th day of each month. If in between the reporting time period there is any evidence of unsafe job performance or any concerns please contact Uprise Health immediately at 1-888-802-2843. This is a confidential document and only should be viewed by staff with a need to know.**

Licensee Name or account#: _____ Evaluation From: _____ To: _____

Employment Setting:
Name of Employer: _____ Workplace setting: _____
Name of Workplace Supervisor/Primary Workplace Monitor: _____ Telephone: _____
Confidential fax_____ Email address:_____

Job Specifications:
Has there been a change in the licensee's position or job description since the last report? (Circle One) yes no
Current Position Title: _____ Start date if new position: _____
Work Hours/Shift: _____
Frequency of contact w/ Licensee: (Circle One) daily, twice a week, weekly, every other week, monthly

Physical performance • Balance • Manual coordination/tremor • Speech patterns • Gait/stance	**Within acceptable limits for workplace** **Yes or No**
Cognitive performance • Mental alertness/concentration • Memory • Accuracy of documentation	**Within acceptable limits for workplace** **Yes or No**
Communication performance • Emotional tone with co-workers and patients • Response to feedback on performance • Maintenance of clear professional boundaries	**Meets Worksite Standard** **Yes or No**
Attendance • Consistent attendance without change in pattern • No unexplained absences	**Meets Worksite Standard** **Yes or No**
Management of Worksite Medications, if applicable • Medication administration/documentation consistency • Adherence to narcotic disposal policy • Authorized access to controlled medication	**Meets Worksite Standard** **Yes or No or NA**

Please describe any behavioral changes since last report:

Comments including any concerns expressed by others pertaining to the licensee's practice:

Would you like to speak with the licensee's agreement monitor? Yes_____ No_____

Signature of Workplace Monitor: _____ Date: _____

Print Name: _____ Title: _____

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