

**Virginia Health Practitioners' Monitoring Program  
Monthly Employer Report**

Name of Participant: \_\_\_\_\_ Client # \_\_\_\_\_ CM: \_\_\_\_\_

Date of Report: \_\_\_\_\_ For Month: \_\_\_\_\_, 20\_\_\_\_\_

Participant's Job Title: \_\_\_\_\_

**Hours worked:**

Average work hours per day: \_\_\_\_\_ Average total hours per week: \_\_\_\_\_

**Shifts worked:**

Day  Evening  Night  Weekend

**Attendance:**

Number of absences: \_\_\_\_\_ Number of late arrivals: \_\_\_\_\_

**Did you see the participant face-to-face this month?**

Yes  No

**Is the participant's conduct professional?**

Yes  No

**Has there been any workplace disciplinary action? If yes, was it written or verbal? Please explain below.**

Yes  No  Written  Verbal

**Please tell us your assessment of this individual's work performance since last month (or the last report you filed) and include supporting comments:**  Very Good  Good  Fair  Poor  Very Poor

Comments/Concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you need more information about the Health Practitioners' Monitoring Program (HPMP) or the participant?**

Yes  No

**Do you need to speak with the participant's case manager?**

Yes  No

**As far as you are aware, does the participant comply with the standards of acceptable and prevailing practice and appear able to practice with reasonable skill and safety?**

Yes  No

**Do you have concerns about the participant's behavior, work performance or compliance with HPMP?**

Yes  No

Person Completing Report (Print Name) : \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Telephone: \_\_\_\_\_

*(Please fax this form to 804-828-5386 by the 10<sup>th</sup> of the month. Thank you for your cooperation!)*

**For Office Use Only**

Date Received by HPMP: \_\_\_\_\_ Case Manager: \_\_\_\_\_