VIRGINIA
Department of Health Professions

PHARMACIST / PHARMACY TECHNICIAN PERFORMANCE EVALUATION

This report covers only the current quarter:

☐ **Jan – Mar** of **20___** or ☐ **Apr – Jun** of **20___** or ☐ **Jul – Sep** of **20___** or ☐ **Oct – Dec** of **20___**

Report must be received from 5 days *before* until 5 days after the end date of current quarter: *e.g. if due 3/31 must receive 3/26 to 4/5*

Note: The employee pharmacist / pharmacy technician asking you to complete this form has been placed on probation or under terms and conditions by an Order of the Virginia Board of Pharmacy. The pharmacist / pharmacy technician must ensure that a performance evaluation is submitted quarterly by his/her supervisor for the duration of the term. **However, any serious concerns/problems should be reported to the Board immediately.**[1]

Were you given complete copy of the Order by the pharmacist / pharmacy technician?
☐ Yes ☐ No **(If no, contact the Board of Pharmacy immediately [1])**

NAME OF EMPLOYEE: _____

DATE EMPLOYED / HIRED: _____ **DATE TERMINATED / RESIGNED** (if applicable) _____

IMMEDIATE SUPERVISOR NAME & TITLE: _____

NAME OF PHARMACIST-IN-CHARGE: _____

NAME OF EMPLOYER: _____

ADDRESS OF EMPLOYER: _____

TELEPHONE NUMBER OF EMPLOYER: _____

EMPLOYEE'S POSITION: ☐ Staff Pharmacist ☐ PIC ☐ Consultant ☐ Pharmacy Technician ☐ Other _____

SHIFT: ☐ Full Time ☐ Part-time Average Hours Worked Per Week: _____

ATTENDANCE: Number of days tardy / absent in past 3 months ____ Does a pattern of absence or concern exist? ☐ No ☐ Yes

QUALITY OF WORK: ☐ Excellent ☐ Satisfactory ☐ Unsatisfactory ***attach explanation***

COMPLAINTS: Have there been any complaints or concerns from co-workers, staff, or customers? ☐ No ☐ Yes ***attach explanation***

DISPENSING ERRORS: Was pharmacist / pharmacy technician responsible for any medication or dispensing errors? ☐ No ☐ Yes [2]

SIGNATURE OF SUPERVISOR / EVALUATOR [3] _____
PRINTED NAME OF SUPERVISOR / EVALUATOR _____
TITLE OF SUPERVISOR / EVALUATOR _____
DATE SIGNED _____
SUPERVISOR / EVALUATOR'S PHONE NUMBER _____

1 **For immediate notifications to the Board, email PharmBd@dhp.virginia.gov or call (804)-367-4456**
2 **Attach copy of front & back of the prescription(s), with patient name(s) legible; prescription profile of pharmacist responsible for checking the prescription(s); and written explanation of error(s).**
3 **If the evaluator is someone other than the immediate supervisor, the signature affirms that the evaluator has consulted with the immediate supervisor prior to submitting this evaluation, and that the immediate supervisor concurs with the evaluation.**

Virginia Board of Pharmacy
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