

CENTRAL STATE HOSPITAL

Employee Competency Checklist (Initial Assessment)

Employee Name: _____

Title: _____

DDO/Unit: _____

Date current license/ certification expires: _____

Indicate completion by placing a checkmark or write N/A if not required.	Due to Human Resources Within 45 Days
	Performance Management Form Reviewed and Signed
	Department Orientation
	Competency Evaluation: Skills Checklist/Equipment Checklist
	Verification of current licensure/certification (if required): Professional License CPR Commercial Drivers License State Drivers License

EMPLOYEE CERTIFICATION

I verify that I have received, reviewed, and understand my responsibilities as described in my Performance Management Form.

Employee Signature Date Evaluating Supervisor Date

SUPERVISOR CERTIFICATION

I verify that the above named employee has completed all of the above requirements applicable to the review period.

Evaluating Supervisor Date DDO/Unit Director Date